MEDICARE PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD, AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

JUNE 25, 2014

Serial No. 113–156

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

91–806 WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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MEDICARE PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD, AND ABUSE

WEDNESDAY, JUNE 25, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:03 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Murphy, Burgess, Blackburn, Olson, Griffith, Johnson, Long, Ellmers, Upton (ex officio), DeGette, Braley, Schakowsky, Tonko, Green, and Waxman (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Matt Bravo, Professional Staff Member; Leighton Brown, Press Assistant; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, O&I; Brittany Havens, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, O&I; Robert Horne, Professional Staff Member, Health; Emily Newman, Counsel, O&I; Macey Sevcik, Press Assistant; Alan Slobodin, Deputy Chief Counsel, Oversight; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Peter Bodner, Democratic Counsel; Brian Cohen, Democratic Staff Director, Oversight and Investigations, Senior Policy Advisor; Lisa Goldman, Democratic Counsel; Elizabeth Letter, Democratic Press Secretary; and Stephen Salsbury, Democratic Investigator.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. I convene this hearing of the Subcommittee on Oversight and Investigations. Today we will be revisiting a subject that every member of this committee believes has gone on for far too long: the fraud, waste, and abuse rampant in our Medicare program.

Last year the Medicare program helped finance the medical services of approximately 51 million individuals and in doing so spent approximately $604 billion. Sadly, a budget that large makes the program a high target for fraud and abuse. Last year the Centers for Medicare and Medicaid Services estimated that improper payments were almost $50 billion. Outside news reports have also pegged the amount lost to fraud as high as $60 billion. This is a shocking amount of taxpayer money to lose every year, especially considering that some experts tell us that we do not even know the

full extent of the problem. These financial losses are simply unacceptable.

To someone unfamiliar with the topic, some of the ways the government improperly pays out Medicare funding may seem completely unbelievable. For example, according to the Department of Health and Human Services Office of Inspector General, just a few years ago the Federal Government managed to pay out $23 million in Medicare funding to dead people. One news story involved an Ohio doctor learning that he was the CEO of a medical practice only when a reporter called him to ask about it, and the practice he was allegedly running. Just a mailbox. Earlier this month news broke about an accusation that one doctor in California was able to help facilitate approximately $22 million in inappropriate Medicare payments for wheelchairs. The economics of this also incentivize abusing the Medicare program as well. Last year the Department of Justice issued a release noting that an individual was able to bill Medicare $6,000 for a wheelchair that cost $900 wholesale.

These are but a few of the more darkly humorous examples. But this is no laughing matter. Quite frankly, it is a national outrage.

It is not only the stories or amounts of money that should shock us all but also the length of time the government has allowed this to continue. Since 1990, 24 years ago, the Government Accountability Office has designated the Medicare program as a high risk for fraud and abuse, a quarter century of wasted taxpayer dollars. When does it all stop? Think for a moment about a single company in the private sector that could lose this much money, year after year. How could they still be in business today?

We recognize that the administration is attempting to solve this problem. In the past few years CMS has implemented new programs to provide enhanced screening for certain categories of providers. If a provider is servicing an area that typically is more susceptible to fraud, they may undergo additional scrutiny. I hope today to hear about how this is working and the number of fraudulent providers that have been stopped before they even entered the Medicare system.

Meanwhile, the administration testified before the Committee on Ways and Means earlier this year on new collaborations with state governments on ways to combat fraudsters from moving their Medicare or Medicaid schemes from one state to another. I hope to also hear an update on this today.

One of the main problems in the past with Medicare fraud was that those combatting it often relied on a pay-and-chase model, that is, pay out claims for Medicare, learn of potential fraudulent activity, and then try to stop the fraud. Our government simply must do better. Today I hope to hear about ways the administration is using new methods to use analytics to stop fraud before it happens. With the technological advances that the Medicare program has seen in its lifetime it simply should be much more difficult for individuals to defraud the program.

And one of the easiest ways to prevent fraud on the system and protect Medicare patients is by excluding the bad actors who have committed crimes in the past, that is, make sure there's a pre-approved list of providers. Yet, news reports indicate that doctors who

should not be billing Medicare continue to do so. Earlier this year one news outlet reported that several doctors who had a lost a medical license were still able to bill the Medicare program for millions of dollars.

Committee staff has identified more problems as well. At least 14 individuals convicted of FDA-related crimes—health providers that have been debarred by the FDA—do not appear to be excluded from the Medicare program. Worse, 6 doctors debarred by the FDA actually were paid over $1 million in Medicare payments in 2012.

Finally, today I hope we hear about the steps that can be taken to further combat fraud. GAO has recommended some common sense steps that would reduce fraud, such as removing social security numbers from Medicare cards, but CMS has yet to implement this recommendation.

I want to thank the witnesses for joining us. And by the way, I also want to note that last night HHS and CMS finally released their report to Congress on the second implementation of the fraud prevention system. We are pleased we finally got this. We hope that these new technologies can yield even greater returns in the future. And I believe this is a committee that pushed for this, and we are pleased we finally got that. Unfortunately, it was last night, so we haven't had a chance to review it fully. It is 9 months late, and if we are truly serious about combatting Medicare fraud, we can't have these delays.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

I convene this hearing of the Subcommittee on Oversight and Investigations. Today we will be revisiting a subject that I and every Member of this Committee believe has gone on for far too long: the fraud, waste, and abuse rampant in our Medicare program.

Last year the Medicare program helped finance the medical services of approximately 51 million individuals and in doing so spent approximately $604 billion. Sadly, a budget that large makes the program a high target for fraud and abuse. Last year the Centers for Medicare and Medicaid Services estimated that improper payments were almost $50 billion. Outside news reports have also pegged the amount lost to fraud as high as $60 billion. This is a shocking amount of taxpayer money to lose every year, especially considering that some experts tell us that we do not even know the full extent of the problem. These financial losses are simply unacceptable.

To someone unfamiliar with the topic, some of the ways the government improperly pays out Medicare funding may seem completely unbelievable. For example, according to the Department of Health and Human Services Office of Inspector General, just a few years ago the federal government managed to pay out $23 million in Medicare funding to dead people. One news story involved an Ohio doctor learning that he was the CEO of a medical practice only when a reporter called him to ask about it; and the "practice" that he was allegedly running? Just a mailbox. Earlier this month news broke about an accusation that one doctor in California was able to help facilitate approximately $22 million in inappropriate Medicare payments for wheelchairs. The economics of this also incentivize abusing the Medicare program as well-last year the Department of Justice issued a release noting that an individual was able to bill Medicare $6,000 for a wheelchair that cost $900 wholesale. These are but a few of the more humorous examples. But this is no laughing matter: it should be a national outrage.

It is not only the stories or amounts of money that should shock you, but also the length of time the government has allowed this to continue. Since 1990—24 years ago-the Government Accountability Office has designated the Medicare program as a high risk for fraud and abuse. A quarter century of wasted taxpayer dollars—when does it stop? Think for a moment about a single company in the private

sector that could lose this much money, year after year, and still be in business today.

We recognize that the administration is attempting to solve this problem. In the past few years CMS has implemented new programs to provide enhanced screening for certain categories of providers. If a provider is servicing an area that typically is more susceptible to fraud, they may undergo additional scrutiny. I hope today to hear about how this is working and the number of fraudulent providers that have been stopped before they even entered the Medicare system. Meanwhile, the administration testified before the Committee on Ways and Means earlier this year on new collaborations with state governments on ways to combat fraudsters from moving their Medicare or Medicaid schemes from one state to another. I hope to also hear an update on this today.

One of the main problems in the past with Medicare fraud was that those combatting it often relied on a "pay and chase" model. That is: pay out claims for Medicare, learn of potentially fraudulent activity, then try to stop the fraud. Our government simply must do better. Today I hope to hear about ways the administration is using new methods to use analytics to stop fraud before it happens—with the technological advances that the Medicare program has seen in its lifetime it simply should be much more difficult for individuals to defraud the program.

And one of the easiest ways to prevent fraud on the system and protect Medicare patients is by excluding the bad actors who have committed crimes in the past. Yet, news reports indicate that doctors who should not be billing Medicare continue to do so: Earlier this year one news outlet reported that several doctors who had lost a medical license were still able to bill the Medicare program for millions of dollars. Committee staff has identified more problems as well: at least 14 individuals convicted of FDA-related crimes—health providers that have been debarred by the FDA—do not appear to be excluded from the Medicare program. Worse, 6 doctors debarred by the FDA actually were paid over $1 million in Medicare payments in 2012.

Finally, today I hope we will hear about the steps that can be taken to further combat fraud. GAO has recommended some common sense steps that would reduce fraud, such as removing social security numbers from Medicare cards, but CMS has yet to implement this recommendation. I would like to thank the witnesses joining us today-you all have the ability to save the American taxpayer a massive amount of money, and we hope to hear from you today on how you plan to do that.

Mr. MURPHY. But now I would like to recognize the ranking member of this committee, Ms. DeGette, for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman. This is the third hearing that the committee has had on Medicare fraud in the last 3 years, and I think it is perfectly appropriate to do that. Medicare fraud wastes money and endangers the care of seniors and the disabled. That is why I think we can work in a bipartisan way, and I am pleased.

We have witnesses today from CMS, the HHS Inspector General, and the GAO with us. I appreciate all of you joining us and look forward to hearing your perspective on where we stand and what we need to do to further reduce Medicare fraud, waste, and abuse.

The administration has also made some important strides in this area. The Healthcare Fraud Prevention and Enforcement Action, or HEAT Teams, a joint effort between HHS and DOJ, have played a critical role in these efforts. Medicare strike forces are a key component of HEAT, interagency teams of analysts, investigators, and prosecutors who can target emerging or migrating fraud schemes, including fraud by criminals masking as healthcare providers or suppliers. These efforts have produced immediate returns. In fiscal year 2012, the government recovered $4.2 billion in fraud, and from

2009 through 2012, it has returned a record-breaking $14.9 billion to taxpayers, more than doubling returns compared to the previous 4 years. CMS has also implemented many of the new tools provided to the agency under the Affordable Care Act. These new provisions of law have marked a dramatic shift in the way CMS fights fraud, moving from the old pay-and-chase model to the newer and much more effective approach of keeping fraudulent providers out of the Medicare system entirely.

New Medicare providers are screened before they are allowed into the program. Providers in risky programs face additional scrutiny. CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare providers and suppliers by 2015. This revalidation effort has deactivated or revoked almost 200,000 providers so far.

The Affordable Care Act also limits the ability of fraudulent providers and suppliers to move from state to state or program to program by requiring all states to terminate providers whose billing privileges have been revoked by Medicare or have been terminated by another state Medicaid program for costs. And the administration has invested in predictive analytic tools that use algorithms and other sophisticated information technology to identify potentially fraudulent behavior. This technology has resulted in leads for more than 500 new fraud investigations and has provided new information for more than 500 existing investigations.

Mr. Chairman, this is good news, but we also have some unfinished work for CMS that we are going to hear from the IG and GAO about. I am particularly concerned about reports that Medicare Part C and D plans may not be doing enough to identify and report fraud. The private Part C and D providers are popular with many beneficiaries and have become a key and growing part of Medicare, and that is why we need to make sure that they are doing as much as traditional Medicare to fight fraud.

And finally, Mr. Chairman, Congress needs to do our part, especially when it comes to financial support for the fraud fighters. Sequestration meant that the CMS program integrity funding declined in the last 2 years, and the majority staff's official hearing memo describes how funding cuts for the OIG will limit the agency's ability to carry out its mission, forcing staff reductions of over 200 people and forcing the IG to close over 2,000 investigative complaints and cut Medicare and Medicaid oversight by 20 percent. So at the same time we are trying to increase a robust program of oversight, we are cutting the funding for investigations. Now, I think we can all agree, this is penny-wise and pound-foolish. There is bipartisan agreement that we need to do more to wipe out Medicare fraud, and there is bipartisan agreement that every dollar spent to reduce fraud brings back more than a dollar in return.

So we should fix this problem. I know a number of members on this and other committees have discussed bipartisan fraud prevention legislation. We should work diligently on that to give the CMS the tools they need to fight fraud, and we need to make sure that all of the fraud fighters have the funding they need to do this important work. And I yield back, Mr. Chairman.

Mr. MURPHY. The gentlewoman yields back. I now recognize the Chairman of the Full Committee, Mr. Upton, for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman. I do share my colleagues' frustration on this issue for sure. It was 24 years ago when the GAO first announced the Medicare program was a big high risk for fraud and abuse. The program's financial sustainability has also been under threat for years. This committee has routinely, on a bipartisan basis, conducted oversight of the Medicare program in an effort to eliminate waste, fraud and abuse. Our goal is to save taxpayer dollars and strengthen the program. While rooting out waste, fraud, and abuse cannot alone keep the promise of Medicare, it is an important step that has the potential to benefit both seniors as well as taxpayers.

To our witnesses here today, we have got a simple question. How can the government continue losing tens of billions of taxpayer dollars every year?

For years, HHS has relied on a pay-and-chase model to recover Medicare losses, learning far too late that fraudsters routinely tricked the Federal Government into paying them. But today there are some predictive methods that can help the government detect the fraud before the payments go out the door.

I hope that today's witnesses will do more to make these tools work.

We should not pay potential fraudsters a dime, let alone the billions we actually do. All taxpayers, and those relying on Medicare, deserve better.

Thank you for being here.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

I share my colleagues' frustration on this issue. It was 24 years ago when the Government Accountability Office first announced the Medicare program was a high risk for fraud and abuse. The program's financial sustainability has also been under threat for years. This committee has routinely conducted oversight of the Medicare program in an effort to eliminate waste, fraud, and abuse. Our goal is to save taxpayer dollars and strengthen the program. While rooting out waste, fraud, and abuse cannot alone keep the promise of Medicare, it is an important step that has the potential to benefit both seniors and taxpayers.

To our witnesses here today, we have a simple question: How can the government continue losing tens of billions of taxpayer dollars every year?

For years, the Department of Health and Human Services has relied on a pay-and-chase model to recover Medicare losses, learning far too late that fraudsters routinely tricked the federal government into paying them. But today there are some predictive methods that can help the government detect the fraud before the payments go out the door. I hope that today's witnesses will do more to make these tools work. We should not pay potential fraudsters a dime, let alone the billions we actually do. All taxpayers, and those relying on the Medicare program, deserve better.

To our witnesses here today: thank you for being here. I realize that bad actors will always be present. But we need to do better. I hope that today we can have a productive discussion about how we can finally move to a fraud-free Medicare system.

Mr. UPTON. I yield now to Dr. Burgess.

Mr. BURGESS. I thank the chairman for yielding and, too, want to welcome our witnesses. I appreciate your being here.

Earlier this year, the CEO of a Texas hospital chain was indicted for defrauding the government of $18 million. The money continued

to flow from the Center for Medicare and Medicaid Services despite the hospital's long record of patient safety violations and billing fraud. Conditions at these facilities were bad. Patients died. In 2012, regulators moved to cut off funds, but a few months later, other officials at the Center for Medicare and Medicaid Services provided well over $1 million to these hospitals.

This case in Texas raises broader questions about CMS's ability to prevent improper payments to fraudulent or even dangerous providers. Providers that are excluded from one federal program because of improper or illegal conduct can often continue to be paid by other programs. It is my belief that providers that have been banned from federal programs for wrongdoing should be excluded from all federal programs. Period. The incident in Texas prompted me to work with Chairman Upton and Mr. Barton. We sent a letter to CMS and the Office of Inspector General. We asked about the screening of providers receiving Medicare payments and other types of federal funds. Dr. Agrawal was kind enough to come into my office to brief me in response to these letters. They have been very helpful and informative, but you still can't help but be disappointed to learn that little progress has been made in this area over several decades.

Numerous audits have been performed. Recommendations have been made in ways to improve the system. Through the miracle of Google you can find these recommendations going back well over 20 years. But 2 decades later, these recommendations continue to be ignored, and taxpayers continue to lose money. The fact is that the Center for Medicare and Medicaid Services is not doing all they can to prevent this type of fraud and abuse of the system. You have the authority to implement tools to prevent abuse. Yet, you have not done so. We are here today to find out why.

I look forward to hearing from our witnesses today and yield the balance of the time to the vice chair of the Full Committee, Ms. Blackburn.

Mrs. BLACKBURN. Thank you, Dr. Burgess, and I want to welcome all of you. You have heard us talk about Medicare fraud, and we know that it is tens of billions of dollars. And it seems like it continues despite RAC audits and ZPICS and CERTS and the additional authorities that you all at CMS have been given, and we still have a permissive approach that allows providers with questionable backgrounds to continue to bill taxpayers. We have heard about doctors enrolled in Medicare who have been convicted of crimes. We have heard about companies that have been found guilty of fraud that are continuing to benefit. They rename themselves. They stay in the process.

People are sick of this. And what we want to hear from you today is what are you going to do about it? If you can't clean it up, let me tell you what. We are going to clean it up. But this is something that just absolutely has to stop. It is not your money. It is not the Federal Government's money. It is the money of the taxpayer and they are fed up with the inept attitudes and approaches that are coming out of some of these agencies.

So we thank you for being here. We are concerned about the persistence of this issue, and we look forward to solving it. I yield back.

Mr. MURPHY. The gentlelady yields back, and now I will recognize the ranking member of the Full Committee, Mr. Waxman, for 5 minutes.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Mr. Chairman, I appreciate your holding this hearing today. I care passionately about the Medicare program, and I want to make sure that we are doing everything we can to wipe out fraud. When I was chairman of this committee, we held hearings and passed legislation as part of the Affordable Care Act that gave CMS new authorities, new resources and a whole new approach to reducing fraud.

We are going to hear today about some of the successes of that new approach. We are also going to hear from Members of the Congress' outrage if there is any fraud. Well, it is outrageous to have any fraud, but it is also outrageous for Members of Congress to say this is outrageous, we are going to solve the problem, and then not hear a solution.

We are seeing some progress. We have seen increases in enforcement, recovery for the taxpayers of that money that has been taken by fraud, and questionable providers have been kicked out of the program. CMS is using new, predictive analytics to sniff out and take action against fraud. And I know the IG and GAO will tell us about the work that CMS still has left to do, and I expect the agency to take additional action to fully implement the Affordable Care Act's anti-fraud provisions and to address other concerns raised by the experts of these two agencies.

I suppose one of the things the Republicans want to do to solve this problem is repeal the Affordable Care Act anti-fraud provisions which they would have done in over 50 times they have tried to get the Congress to repeal the whole law, everything.

We should be working in a bipartisan way in Congress to address anti-fraud funding shortfalls caused by the sequester and close gaps in Medicare law identified by the administration and by GAO and by the IG. There is no reason we can't work together on these issues, unless we just want to use them for talking points in an election year or the year before the next election.

But Mr. Chairman, we need to address Medicare waste, fraud, and abuse. We need to look at all three of these areas, and probably the biggest source of waste of taxpayer funds in Medicare are the high prices that Medicare Part D plans pay for prescription drugs.

Mr. Chairman, last week I wrote a letter to you and Chairman Upton requesting that the committee hold a hearing on the implications of the high cost on the Medicare Part D program of Sovaldi, the new Hepatitis C drug manufactured by Gilead Pharmaceuticals, and I hope we hold this hearing. Sovaldi has been hailed as a breakthrough treatment for individuals suffering from Hepatitis C, but it is costly: $1,000 per pill, or $84,000 for the entire 12-week course of treatment. And there are an estimated 350,000 Medicare Part D beneficiaries with Hepatitis C.

As a result, a recent analysis was done by researchers from Georgetown University and Kaiser Family Foundation that said Medicare Part D will be spending $6.5 billion or 8 percent in 2015 for this one drug.

Mr. Chairman, this problem is exacerbated by the fact that Medicare Part D plans are not able to effectively negotiate for lower prices for Sovaldi or any other drug. While Gilead provides substantial discounts on the drug in other countries, and for the VA and the Medicaid program, these discounts are not available to Medicare Part D plans.

The result of this inability of Medicare Part D plans to negotiate for lower drug prices is the waste of hundreds of billions of taxpayers' dollars. This is a problem we should solve, at least examine. I hope this committee will hold a hearing, but I have written a lot of letters asking for hearings and if it affects the fossil fuel industry, forget about it. If it affects the pharmaceutical industry, well, they are big campaign contributors. But we ought to look into this issue.

We could save money, and we could be doing the Medicare program a great service and we could be doing people who need this drug a great service. At least we ought to look at the problem.

But today's hearing on reducing Medicare fraud is useful. Let us approach it in a constructive manner. I thank the witnesses for being here today, and I yield back the balance of my time.

Mr. MURPHY. The gentleman yields back. And I would like to introduce the witnesses on the panel for today's hearing. Dr. Shantanu Agrawal. Did I say that correctly?

Dr. AGRAWAL. That is correct.

Mr. MURPHY. Thank you. The Deputy Administrator and Director of the Center for Program Integrity of the Centers for Medicare and Medicaid Services. Mr. Gary Cantrell is a Deputy Inspector General for Investigations, the Office of Inspector General at the Department of Health and Human Services. Today Mr. Cantrell is accompanied by Ms. Gloria Jarmon. She is the Deputy Inspector General for Audit Services in the Office of Inspector General at the Department of Health and Human Services. Ms. Kathleen King is the Director of Health Care at the U.S. Government Accountability Office.

I will now swear in the witnesses. You are aware that the committee is holding and investigative hearing and when doing so has the practice of taking testimony under oath. Do any of you have any objections to testifying under oath?

None of the witnesses have indicated that. So the chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during your testimony today?

All the witnesses decline that. So in that case, would you all please rise and raise your right hand and I will swear you in?

[Witnesses sworn.]

Mr. MURPHY. Thank you. All of the witnesses said yes, so you are now under oath and subject to the penalties set forth in Title 18, Section 1001 of United States Code.

I will ask all of you to give a 5-minute opening statement summary. Dr. Agrawal, we will begin with you.

STATEMENT OF SHANTANU AGRAWAL, M.D., DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES; GARY CANTRELL, DEPUTY INSPECTOR GENERAL, INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND KATHLEEN M. KING, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF SHANTANU AGRAWAL

Dr. AGRAWAL. Thank you. Chairman Murphy, Ranking Member DeGette, and members of the committee and subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' program integrity efforts. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share a commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services. I would like to make three major points in my oral remarks this morning. First, our work in implementing new provider enrollment and screening standards at CMS has had significant, tangible program integrity impacts and moved us firmly towards prevention on these issues.

Second, we recognize that further work remains to improve our safeguards, and we are taking specific, proactive steps toward those improvements. And finally, one of our many tools is our advanced predictive analytic system, the fraud-prevention system, which has continued to develop and deliver a positive return on investment in just the second year of operation. That ROI has been certified by the Office of Inspector General.

Thanks in part to the authorities and resources provided by the Affordable Care Act and the Small Business Jobs Act of 2010, CMS is changing the program integrity paradigm toward a focus on prevention to identify and combat waste, abuse, and fraud in our system. Our enhanced screening requires certain categories of providers and suppliers that have historically posed the higher risk of fraud to undergo greater scrutiny prior to their enrollment in Medicare.

The Affordable Care Act also required CMS to revalidate all existing 1.5 million Medicare suppliers and providers under the new screening requirements. We have real, tangible results from these efforts to share. Since March 25, 2011, more than 930,000 providers and suppliers have been subject to these new screening and validation requirements. Over 350,000 providers and suppliers have had their billing privileges deactivated as a result of revalidation and other screening efforts, and over 20,000 providers and suppliers have had their billing privileges entirely revoked. Just since the start of this year, CMS has revoked over 800 providers for lack of appropriate licensure. These deactivations and revocations mean these providers can no longer bill or be paid by Medicare.

Our experiences with provider screening tell us that there is more work to be done to continue to enhance the screening process. We already rely on over 200 databases in our current screening processes, but challenges remain. For example, CMS has histori-

cally relied on Medicare exclusion and GSA debarment data to identify relevant felony convictions because there is not a centralized or automated means of obtaining felony conviction data. Using these databases on an automated basis, CMS ensures that individuals convicted of healthcare fraud, related crimes or other conduct that bars them from contracting with the Federal Government are denied enrollment to Medicare or swiftly removed from the program as part of our routine screening and validation.

However, to address the lack of an off-the-shelf solution for all criminal data, CMS is developing a process to match enrollment data against numerous public and private data sources to ensure receipt of timely conviction data. Additionally, in April 2014, CMS announced that high-risk providers will now be subject to fingerprint-based background checks to gain or maintain billing privileges for Medicare.

We are also applying our enrollment and screening processes more broadly. Just a few weeks ago, CMS issued a final rule to extend enrollment requirements to Part D which prevents revoked or excluded providers from prescribing to Medicare beneficiaries. The same rule also allows us to use data from the Drug Enforcement Agency to ensure prescribers are appropriately licensed to prescribe certain drugs and enable CMS to remove them from Medicare when the DEA has taken an action against an individual's license.

In addition to enhanced provider screening procedures, CMS is using private-sector tools and best practices to stop improper payments of all types. Since June 2012, the fraud prevention system has applied advanced analytics on all Medicare fee-for-service claims on a streaming national basis. In its second year of operations and through over 70 active models in the system, FPS identified or prevented more than $210 million in improper Medicare payments, double the previous year, and resulted in CMS taking action against 938 providers and suppliers. The tool is part of CMS comprehensive program integrity strategy. For example, the FPS is used as part of an agency focus on home health services in South Florida which includes our screening processes, implementation of an enrollment moratorium, on-the-ground investigations and collaboration with law enforcement.

CMS is expanding the use of FPS beyond the initial focus on identifying potential fraud into the areas of waste and abuse which we expect to increase future savings. While we have made significant progress to address areas of vulnerability, we also know that more work remains to further refine our efforts and prevent improper payments and fraud in the first place.

I look forward to answering the subcommittee's questions on how we can improve our commitment to protecting taxpayer and trust fund dollars while also protecting, I think very importantly, beneficiaries' access to safe, high-quality care. Thank you.

[The prepared statement of Dr. Agrawal follows:]

STATEMENT OF

SHANTANU AGRAWAL, M.D.
DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR PROGRAM INTEGRITY
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"MEDICARE PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD AND ABUSE"

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
ENERGY & COMMERCE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

JUNE 25, 2014

U.S. House Committee on Energy & Commerce
Subcommittee on Oversight & Investigations
Hearing on
"Medicare Program Integrity: Screening Out Errors, Fraud and Abuse"
June 25, 2014

Chairman Murphy, Ranking Member DeGette, Vice Chairman Burgess and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts to strengthen provider enrollment. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share this Subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. We have made important strides in reducing waste, fraud and abuse across our programs with the strong support of this Committee and the Congress, and I appreciate the opportunity to detail the tangible results from these improvements.

CMS is using a multi-faceted strategy to target all causes of waste, abuse and fraud that result in inappropriate payments by shifting towards prevention-oriented activities. Thanks in part to the authorities and resources provided by the Affordable Care Act and the Small Business Jobs Act of 2010, CMS has powerful tools to ensure that only legitimate providers are enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). CMS has enhanced the provider enrollment and screening process, which includes risk-based screening that increases the level of scrutiny for providers designated to the moderate and high screening levels. CMS is revalidating all of the Medicare program's existing providers to ensure that only qualified and legitimate providers can provide health care items and services to Medicare beneficiaries. As result of these efforts, over 20,218 providers and suppliers have had their billing privileges revoked, preventing these entities from billing Medicare.

In 2014, as program integrity efforts mature, CMS is applying three key operational principles to guide all of our initiatives. First, we aim to achieve operational excellence in addressing the full spectrum of program integrity causes, in taking swift administrative actions, and in the performance of audits, investigations and payment oversight. Second, CMS will provide leadership and coordination in program integrity efforts across the healthcare system. Finally, we

will focus on impacting the cost and appropriateness of care across healthcare programs. Fraud can inflict real harm to Medicare patients. When fraudulent providers steal a beneficiary's identity and bill for services or goods never received, the beneficiary may later have difficulty accessing needed and legitimate care. Medicare beneficiaries are at risk when fraudulent providers perform medically unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations or medical necessity. Our efforts are focused on ensuring that beneficiaries receive appropriate health care services, protecting both beneficiaries and taxpayers from unnecessary costs. In addition to CMS's ongoing program integrity efforts, the President's Fiscal Year (FY) 2015 Budget reflects the Administration's commitment to strong program integrity initiatives, which includes investments that will yield $13.5 billion in gross savings for Medicare and Medicaid over 10 years.

Strengthening provider enrollment

A critical component to preventing waste, fraud and abuse is to ensure that only legitimate providers have the ability to bill Medicare in the first place. Provider enrollment is the gateway to billing the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the Medicare program.

Risk-based screening of providers

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare. All Medicare providers undergo a baseline screening, including confirmation of the provider's Social Security Number through the Social Security Administration, license and certification through the state licensing boards, as well as searches in the System for Award Management, operated by the General Services Administration (GSA), in terms of Government contracting exclusion (suspension and debarments) and the HHS Office of Inspector General (OIG) exclusion list for all individuals listed on the application.

Under section 1128 of the Social Security Act, the Secretary, through HHS OIG, must exclude individuals and entities from Federal health care programs based on felony or misdemeanor convictions related to the Medicare or Medicaid programs, or related to the abuse or neglect of patients, and has discretionary authority to exclude individuals on a number of grounds, including misdemeanor convictions related to health care fraud. Once approved, enrolled providers are systematically compared weekly to the Social Security Administration's Death Master File and the Medicare Exclusion Database (MED), CMS's repository of information contained in the OIG's exclusion list, and CMS routinely revokes billing privileges based on this information. Revocations are retroactive to the date of a provider's respective plea or conviction, and if the provider submitted claims after that date, CMS demands those payments be repaid.

CMS has historically relied on the MED and GSA list to identify relevant felony convictions because there is not a centralized or automated means of obtaining felony convictions of Medicare providers. CMS is currently working on a process to match enrollment data against public and private databases to receive timely felony conviction data. Additionally, in April 2014, CMS announced that upon notification, providers designated to the high screening level will be required to submit fingerprint-based background checks to gain or maintain billing privileges for Medicare. The requirement applies to individuals with a five percent or greater ownership interest in a newly-enrolling durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) supplier or a newly-enrolling home health agency (HHA), as well as any provider that has been subject to certain adverse actions, including prior revocation, payment suspension, or licensure suspension or revocation.

State Medicaid agencies may rely on the screening done by CMS for dually-enrolling providers to assist them in complying with the requirement to terminate any provider that has been terminated by Medicare or another state Medicaid program for cause. Additionally, CMS has the discretionary authority to revoke Medicare billing privileges where a state has terminated or revoked a provider's or supplier's Medicaid billing privileges. [1] CMS established a process for

[1] Note: This authority was created by: http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf

states to report and share information about Medicaid termination. States have been instructed to report all "for cause" Medicaid terminations, for which state appeal rights have been exhausted, to CMS by submitting a copy of the original termination letter sent to the provider, along with specific provider identifiers, and the reason for Medicaid termination. Over the past seven months, CMS has reviewed 400 Medicaid terminations, and CMS has revoked nearly 50 Medicare providers based on this information. This prevents bad actors from jumping from program to program.

Revalidation of existing Medicare providers

The Affordable Care Act also required CMS to revalidate all existing 1.5 million Medicare suppliers and providers under the new screening requirements. Since March 25, 2011, more than 930,000 providers and suppliers have been subject to the new screening requirements and over 350,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of revalidation and other screening efforts.[2] As previously noted, since the implementation of these requirements, CMS has revoked 20,219 providers' and suppliers' ability to bill the Medicare program as a result of felony convictions, practice locations that were determined to be non-operational at the address CMS had on file, or non-compliance with CMS rules, such a licensure requirements.

Expanding and strengthening provider enrollment requirements

The success of our provider enrollment and screening efforts has demonstrated the importance of preventive actions to ensure that only legitimate providers are serving our beneficiaries. In April 2013, CMS issued a proposed rule that would provide CMS with additional authority to remove bad actors from the Medicare program. CMS proposed to permit denial of an enrollment application of a provider affiliated with a defunct provider with an outstanding Medicare debt, revocation of a provider for a pattern or practice of submitting claims for services that fail to meet Medicare requirements, and clarifying the list of felony convictions that may result in a denial or revocation enrollment.

[2] Deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

In May 2014, CMS issued a final rule that requires prescribers of Part D drugs to enroll in Medicare or have a valid opt-out affidavit on file by June 2015. CMS also established a new revocation authority for abusive prescribing patterns that will be effective in July 2014. Additionally, Medicare enrollment could be revoked if a prescriber's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs.[3]

Enrollment Moratoria

CMS has used the authority provided to the Secretary in the Affordable Care Act to temporarily pause the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud. In July 2013, CMS announced temporary moratoria on the enrollment of new HHAs and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulances in and around Houston.[4] In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in the metropolitan Philadelphia area.[5] CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months.

In each moratorium area, CMS is taking administrative actions such as payment suspensions and revocations of home health agencies and ambulance companies, as well as working with law enforcement to support investigations and prosecutions. In Miami alone, CMS has revoked the billing privileges of 101 HHAs in 2013, with 67 revocations occurring after the moratorium was

[3] http://oig.hhs.gov/oei/reports/oei-02-09-00608.pdf
[4] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html
[5] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

put into place. Additionally, law enforcement made arrests in a $48 million Miami home health scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme. In Texas, CMS has revoked the billing privileges of 179 ambulance companies in the last 12 months, and 92 revocations occurring after the moratorium was put into place in Houston.

Proper and Accurate Claims Payment

CMS performs education, prepayment, and post-payment activities to ensure that payments are made properly and accurately. CMS has designed its claims processing systems to detect anomalies on the face of the claims whenever possible. For example, CMS is using the National Correct Coding Initiative (NCCI) to stop claims that never should be paid in Medicare Part B and Medicaid. This program was first implemented with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians. In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program. MUE edits prevent payments for services such as hysterectomy for a man or prostate exam for a woman. NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation. Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website. The use of the NCCI procedure-to-procedure edits saved the Medicare program $530 million in FY 2013, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over $7.5 billion since 1996 based on savings reports from claims-processing contractors.

Prior Authorization

CMS also develops targeted demonstrations related to areas that have been consistently problematic, such as the Powered Mobility Device (PMD) benefit, where CMS found that over

80 percent of claims for PMDs did not meet Medicare coverage requirements.[6] CMS implemented the Medicare Prior Authorization of PMDs Demonstration in seven high risk states in September 2012.[7] Since implementation, CMS observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims submitted as of April 4, 2014, monthly expenditures for the PMDs included in the demonstration decreased from $20 million in September 2012 to $6 million in December 2013 in the non-demonstration states and from $12 million to $3 million in the demonstration states.[8]

Based on this success, CMS announced plans to expand the demonstration to an additional 12 states.[9] CMS also proposed to establish a prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies items that are frequently subject to unnecessary utilization. Through a proposed rule issued in May 2014, CMS solicited public comments on this prior authorization process, as well as criteria for establishing a list of durable medical items that are frequently subject to unnecessary utilization that may be subject to the new prior authorization process.[10] CMS will also launch two payment models to test prior authorization for certain non-emergent services under Medicare.[11] Information from these models will inform future policy decisions on the use of prior authorization.

The President's FY 2015 Budget also includes a proposal to give CMS the authority to require prior authorization for all Medicare fee-for-service items, particularly those items at the highest risk for improper payment. By allowing prior authorization on additional items, CMS can ensure in advance that the correct payment goes to the right provider for the appropriate service, and preventing potential improper payments before they are made.

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[6] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

[7] The seven states are: CA, IL, MI, NY, NC, FL and TX

[8] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/MedicarePriorAuthorizationofPowerMobilityDevicesDemonstration_05212014.pdf

[9] The twelve states are: AZ, GA, IN, KY, LA, MD, MO, NJ, OH, PA, TN, and WA

[10] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-05-22.html

[11] These services include hyperbaric oxygen therapy and repetitive scheduled non-emergent ambulance transport.

Medical Review

The detection of improper payments can sometimes require an evaluation of the medical record – to identify documentation errors for example – which is not submitted with claims. CMS and its Medicare Administrative Contractors (MACs) develop medical review strategies using the improper payment data to ensure that we target the areas of highest risk and exposure. The review strategies range from issuing comparative billing reports to encouraging providers to conduct self-audits or targeting medical review of specific providers. Comparative reports educate providers about their billing practices by showing the provider in comparison to his or her state and national peers. The MACs reported that medical review resulted in $5.6 billion in savings for FY 2013.[12]

Fraud Prevention System

Under the Small Business Jobs Act of 2010, CMS is required to use predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse in our Medicare fee-for-service program. Since June 2011, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation by CMS's Zone Program Integrity Contractors (ZPICs). The ZPICs then identify administrative actions that can be implemented swiftly, such as revocation, payment suspension, or prepayment review, as appropriate. The FPS is also an important management tool, as it prioritizes leads for ZPICs to review and investigate Medicare fraud in their designated region, making our program integrity strategy more data-driven.

Results from the FPS demonstrate a positive return on CMS's investment, and in its first year of implementation, the FPS stopped, prevented, or identified an estimated $115.4 million in improper payments.[13] These savings are the outcome of activities such as revocations of provider billing privileges, the implementation of payment edits, the

[12] http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf
[13] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

suspension of payments, and changes in behavior that result from CMS actions. The administrative actions and associated savings increased substantially in the second implementation year, indicating the FPS is getting better at identifying fraud, waste, and abuse.

CMS is also piloting the use of the tool with the MACs to see if they can change aberrant billing behavior by directly contacting providers flagged in the FPS. Based on the small pilot, CMS has seen changes in billing behavior in half of the providers contacted within one month, and of the remaining, additional actions were taken, including self-audit and prepayment review.

Leadership and Coordination Across the Health Care System

CMS is coordinating a variety of efforts with Federal and state partners, as well as the private sector to better share information to combat fraud. CMS issued new compliance program guidelines to assist Medicare Advantage plans and prescription drug plans in designing and implementing a comprehensive plan to detect, correct and prevent waste, abuse, and fraud. In September 2013, CMS directed the Part C and D program integrity contractor to increase its focus on proactive data analysis. As a result, the contractor performed analyses that identified the following improper payments: $4.8 million from deceased provider payments, $21 million for unallowable charges for medication during hospice stays, and $80 million for Transmucosal Immediate Release Fentanyl drugs without a medically-acceptable indication. To increase the impact of the proactive analysis, CMS issued a final rule that allows CMS, the OIG and the Government Accountability Office to request and collect information directly from pharmacy benefit managers, pharmacies and other downstream entities of Part D plans.

Collaborating with law enforcement and the private sector

Earlier this year, the Government announced that in FY 2013, its waste, abuse, and fraud prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of $4.3 billion in taxpayer dollars from

individuals trying to defraud Federal health care programs serving seniors and taxpayers.[14] Over the last five years, the Administration's enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period. Over the last three years, the average return on investment (ROI) of the HCFAC program is $8.10 for every dollar spent, which is an increase of $2.70 over the average ROI for the life of the HCFAC program since 1997. As a result of these and other efforts, there has been a measurable decrease in Medicare payments for certain medical services that have also been targeted by the Medicare Strike Force.

Healthcare Fraud Prevention Partnership

In July 2012, the Secretary of HHS and the Attorney General announced a ground-breaking partnership with the private sector to fight fraud, waste, and abuse across the health care system. The ultimate goal of the Healthcare Fraud Prevention Partnership (HFPP) is to exchange facts and information to identify trends and patterns that will uncover fraud, waste and abuse that could not otherwise be identified. The HFPP currently has 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. In 2013, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions to stop payments from going out the door.

Improving Data Transparency

CMS recently released new, privacy-protected data on services and procedures provided to Medicare beneficiaries by physicians and other health care professionals. Release of physician-identifiable payment information serves a significant public interest by increasing transparency of Medicare payments to physicians, which are governed by statutory requirements, and shed light on potential Medicare waste, fraud, and abuse. The new data also show payment and submitted charges, or bills, for those services and procedures by provider. The new data set has information for over 880,000 distinct health care providers who collectively received $77 billion in Medicare payments in 2012, under the Medicare Part B fee-for-service program. With this data, it is possible for the public to conduct a wide range of analyses that compare 6,000 different

[14] http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf

types of services and procedures provided, as well as payments received by individual health care providers.

Later this year, CMS will release additional data to help consumers make informed choices under the Open Payments program. As required by the Affordable Care Act, the data will provide information about payments to physicians made by certain manufacturers of covered drugs and devices. This program is a resource for beneficiaries, consumers, and providers to better understand relationships between physicians, teaching hospitals, and industry. Collaboration among physicians, teaching hospitals, and industry manufacturers can contribute to the design and delivery of life-saving drugs and devices. However, while some collaboration is beneficial, payments from manufacturers to physicians and teaching hospitals can also introduce conflicts of interests.

Moving Forward

Our health care system should offer the highest quality and most appropriate care possible to ensure the well-being of individuals and populations. CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive, or fraudulent services. But the importance of program integrity efforts extends beyond dollars and health care costs alone. It is fundamentally about protecting our beneficiaries and ensuring we have the resources to provide for their care. Although we have made significant progress by implementing important policies to improve provider screening, we are continually refining our policies and processes. We share this Subcommittee's commitment to protecting taxpayer and Trust Fund dollars, while also protecting beneficiaries' access to care, and look forward to continuing this work.

Mr. MURPHY. Thank you. Mr. Cantrell, you have 5 minutes.

STATEMENT OF GARY CANTRELL

Mr. CANTRELL. Good morning, Mr. Chairman, and other distinguished members of the committee. I am Gary Cantrell, Deputy IG for Investigations, and I am joined today by my colleague, Gloria Jarmon, who is Deputy IG for Audit Services.

Thank you for the opportunity to testify about OIG's efforts to fight fraud, waste and abuse in Medicare and Medicaid. OIG utilizes a range of tools in this fight including audits, evaluations, investigations, enforcement authorities and educational outreach. We focus our resources on areas most vulnerable to fraud so we obtain the greatest impact from our work.

OIG works closely with the Department of Justice, CMS, and other federal and state law enforcement partners to bring those who commit fraud against our programs to justice. Our Medicare fraud strike force teams, located in nine cities throughout the country, exemplify this approach. The OIG and our partners are committed to fighting and preventing fraud, waste, and abuse.

Our efforts have produced impressive results. In 2013, our work resulted in record numbers of criminal convictions and civil actions, and over the last 5 years, we have recovered more than $19 billion from those defrauding federal healthcare programs, and our return on investment is over $8 for every dollar spent. Perhaps even more important, we are seeing strong indicators of a deterrent effect. When we work together to shed light on program vulnerabilities, put criminals behind bars and CMS takes appropriate administrative actions, our efforts are most successful. We have seen significant declines in Medicare payments across several program areas in strike force cities where we focused our efforts.

For example, following federal enforcement and oversight activities, there have been sustained declines in Medicare payments for DME, home health, ambulance, and community mental health centers, or CMHCs. Nationwide, Medicare payments for CMHCs have decreased by approximately $250 million annually.

Total Medicare payments for ambulance services in Houston are down approximately 50 percent. Miami area DME payments have decreased by approximately $100 million annually since the launch of the strike force. And since 2010, home health payments have decreased nationally more than $1 billion annually.

Despite these successes, more needs to be done. Fraud schemes are constantly evolving and migrating, and some of the IG's top oversight priorities include the rise in prescription drug fraud and schemes involving home base services.

Rarely are these schemes perpetrated by one provider operating independently. There is often a network of individuals including business owners, patient recruiters, healthcare practitioners, and sometimes even the patients. Kickbacks in the form of cash or drugs bind these networks together.

The federal forfeitures are a valuable tool to help defund and disrupt illegal activities and can serve as a powerful deterrent. Empowering OIG to execute forfeiture warrants would help curb the profitability of healthcare fraud and exert a deterrent effect. Removing Social Security numbers from Medicare cards could also

protect patient data and disrupt fraud schemes. The theft of patient and provider data underpins many of our cases. In a recent case, criminals perpetrated a $100 million fraud scheme by stealing the identities of doctors and thousands of patients.

In conclusion, I must note that OIG's mission is challenged by declining resources at a time when our oversight responsibilities are growing. OIG is responsible for oversight of about 25 cents of every federal dollar. However, since 2012, we have lost 200 employees and expect to reduce our Medicare and Medicaid oversight by 20 percent by the end of the fiscal year. Now is not the time to reduce oversight in the face of a growing and changing program, and OIG is a proven investment. We would appreciate the committee's support in securing full funding of OIG's 2015 budget request. And thank you for the interest and opportunity to testify. We would be happy to answer any questions.

[The prepared statement of Mr. Cantrell follows:]

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony of:
Gary Cantrell
Deputy Inspector General for Investigations
Office of Inspector General
U.S. Department of Health and Human Services

Hearing:
"Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"

House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

June 25, 2014
2123 Rayburn House Office Building
10 AM

Testimony of:
Gary Cantrell
Deputy Inspector General for Investigations
Office of Inspector General
U.S. Department of Health and Human Services
Hearing Title: "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Good morning, Mr. Chairman and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General's (OIG) efforts to improve Medicare oversight and reduce waste, fraud and abuse. Fighting waste, fraud, and abuse in Medicare and other Department programs is a top priority.

We have seen strong results from coordinated Federal and state enforcement efforts across the country, including those of the Medicare Fraud Strike Force teams. Criminal prosecutions and monetary recoveries have increased while we have seen a measurable decrease in payments for certain health care services targeted by fraud schemes. Following targeted enforcement and other oversight activities, payments for CMHCs nationally decreased from $70 million to under $5 million per quarter.[1]

Coordination between the Strike Force teams and the Centers for Medicare & Medicaid Services (CMS) has also contributed to a dramatic decline in payment for home health care in Miami and throughout Florida. After OIG uncovered billing schemes relating to home health outlier payments, CMS put into effect a limit on the percentage of outlier payments that each home health agency (HHA) can claim. Since 2010, Medicare payments for home health care nationally decreased by more than $300 million per quarter, more than $1 billion annually.[2]

We have also seen sustained declines in Medicare payments for durable medical equipment (DME) and ambulance services in targeted areas following Federal enforcement and oversight action. Total Medicare payments for ambulance services in Houston are down approximately 50 percent from $32 million to $16 million per quarter since 2010.[3] Miami-area DME payments have decreased by approximately $100 million annually since launch of the Medicare Fraud Strike Force in Miami in 2007.[4]

These successes are funded through the Health Care Fraud and Abuse Control Program (a joint program of the Department, OIG, and the Department of Justice to fight waste, fraud, and abuse

[1] See Appendix 1, slide titled *Outcomes: CMHC Payment Trends*.
[2] See Appendix 1, slide titled *Outcomes: HHA Payment Trends*. See also *Healthcare Fraud and Abuse Control Program Annual Report for Fiscal Year 2013*, p.13; available at http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf.
[3] See Appendix 1, slide titled *Outcomes: Ambulance Payment Trends*.
[4] See Appendix 1, slide titled *Outcomes: DME Payment Trends*.

in Medicare and Medicaid), which returns more than $8 for every $1 invested.[5] However, more remains to be done. In March 2014, OIG issued its *Compendium of Priority Recommendations*, which highlights additional opportunities for cost savings and program and quality improvements.[6] Implementing these recommendations could result in billions of dollars saved and more efficient and effective programs. My testimony today focuses on a selection of key recommendations from the *Compendium* and other program integrity recommendations consistent with OIG's work, provides an overview of current fraud trends, and highlights challenges that impede effective oversight of Medicare and Medicaid.

Current Trends in Health Care Fraud

Fraud schemes are constantly evolving. As enforcement efforts target certain schemes, new permutations of those schemes arise. Not only are fraud schemes mutating, they are migrating – geographically and even between parts of the Medicare program. Some of OIG's highest priorities and concerns involve the emergence of criminal networks in healthcare fraud, the rise in prescription drug abuse and diversion, and the provision of illegitimate home-based care.

Criminal Networks

Over the past several years OIG has seen an increase in organized criminal elements committing health care fraud. This may be attributed to the ease of entry into some sectors of the health care industry, the lucrative nature of health care fraud, the belief that it is less violent than other types of crime, or a perception of reduced criminal penalties. Criminal networks have become a pervasive problem in DME, home health, outpatient clinics, and pharmacies. Schemes typically involve kickbacks, nominee owners, recruiters, and money laundering. In one particular Strike Force case, an organized criminal network used a fraudulent medical clinic to bill Medicare over $77 million for services that were medically unnecessary and never provided. Co-conspirators included clinic owners; a medical director who was rarely on site at the clinic; money laundering operatives; and complicit Medicare beneficiaries, who accepted regular cash kickbacks. Over a dozen co-conspirators have been sentenced to an aggregate total of more than 45 years in prison, over $50 million in restitution, and millions more in asset forfeiture. The clinic owner and criminal network leader was sentenced to 15 years in prison, excluded from all Federal health care programs, and ordered to forfeit over $36 million. The medical director was sentenced to over 12 years in prison and ordered to forfeit more than $500,000.

Federal forfeitures are a valuable tool to help defund and disrupt illegal activities and can serve as a powerful fraud deterrent. However, OIG lacks the authority to execute warrants for seizure of property for forfeiture. We must instead seek assistance from other law enforcement agencies in securing and executing relevant warrants – this has resulted in administrative inefficiencies

[5] The $8 to $1 return on investment is a 3-year rolling average from fiscal year (FY) 2010-2013. For more details on this and other HCFAC accomplishments, see the *FY 2013 Health Care Fraud and Abuse Control Program Report*, available at http://oig.hhs.gov/reports-and-publications/hcfac/index.asp.

[6] Office of Inspector General's *Compendium of Priority Recommendations*, March 2014, available at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

and costly delays. In one recent case, OIG agents identified an account into which proceeds of Medicare fraud were being deposited. By the time we enlisted another agency to obtain and issue seizure warrants, the estimated $1.3 million in the account had been withdrawn. To ensure that the Federal government and taxpayers are made whole for losses due to health care fraud, it is important that Federal law enforcement move immediately after identifying assets that are the proceeds or fruits of criminal activity. Empowering OIG to execute forfeiture warrants would be a step in helping ensure this outcome.

Medical identity theft is a prevalent and increasing crime that is closely linked to Medicare fraud schemes, especially those involving criminal networks. Although beneficiaries can be complicit in criminal network operations, in one Strike Force case, subjects perpetrated a 100 million dollar Medicare fraud scheme that involved stealing the identities of doctors and thousands of Medicare beneficiaries for use in phony clinics around the country.

Key OIG recommendations include:

- Provide OIG with authority to execute Federal warrants for the seizure of assets for forfeiture to curb the profitability of healthcare fraud, which will exert a deterrent effect.
- Remove Social Security numbers (SSN) from Medicare cards to help protect the personally identifiable information of Medicare beneficiaries.

Prescription Drug Fraud

Medicare Part D, the prescription drug program, in calendar year 2012 cost $66.9 billion in expenditures for 30 million enrolled beneficiaries. OIG has extensively examined CMS's monitoring and oversight of the Part D program and the effectiveness of controls to ensure appropriate payment and patient safety. Our work has found limitations in program safeguards that leave Part D vulnerable to improper payments and Medicare patients vulnerable to potentially harmful prescribing. These include extreme outlier provider prescribing patterns and questionable billings by numerous retail pharmacies nationwide.[7] The prescription fraud schemes are complex crimes involving many co-conspirators, including health care professionals, patient recruiters, pharmacies, and complicit beneficiaries. An increasing percentage of OIG work involves prescription drug fraud.[8] In FY2013 alone, OIG opened 312 new Part D investigations; this is an 80 percent increase over FY2009.

Overprescribing of controlled substances can lead to patient harm. Of particular concern are cases in which patient deaths occur as a result of prescription drug diversion or "doctor shopping." In one example, a physician was arrested for prescribing oxycodone-based products to bogus patients who were complicit beneficiaries that received $150 cash per office visit for

[7] See, e.g., *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608, June 2013, available at http://oig.hhs.gov/oei/reports/oei-02-09-00608.asp; *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012, available at http://oig.hhs.gov/oei/reports/oei-02-09-00600.asp; *Prescribers With Questionable Patterns In Medicare Part D*, OEI-02-09-00603, June 2013, available at http://oig.hhs.gov/oei/reports/oei-02-09-00603.asp.

[8] See *Spotlight on Drug Diversion*, available at http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp.

their participation in the scheme. The complicit beneficiaries then used their Medicare, Medicaid or private insurance cards and cash to pay for the filled prescriptions at various pharmacies and then sold them for $300-$1000 to various drug-trafficking organizations, which then resold the drugs on the street. This scheme resulted in the illegal distribution of more than 700,000 pills of oxycodone, including one patient death. The physician was sentenced to 20 years in prison and forfeited $10 million. A total of 61 defendants have been sentenced to a combined 253 years in prison.

Prescription drug fraud involving non-controlled substances is becoming more common. The billing but not dispensing of non-controlled medications presents a massive financial loss to the Medicare program. Schemes typically involve brand-name, high-cost medications, including respiratory, HIV/AIDS, and anti-psychotic medications, along with co-conspirator beneficiaries who assist in obtaining the prescriptions in exchange for a kickback. In one south Florida case, a pharmacy was found to be billing but not actually dispensing expensive non-controlled medications. The pharmacy received fake invoices from a wholesaler to cover this shortage. OIG special agents infiltrated the wholesale company and arrested the owner. During the investigation it was discovered that the wholesaler had supplied fake invoices to 17 other local pharmacies.

Key OIG recommendations include:

- Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns.
- Require Part D plans to verify that prescribers have the authority to prescribe.

CMS issued a proposed rule that would require all prescribers of Part D drugs to be enrolled in the Medicare fee-for-service program (or officially opt out).[9] If implemented, this requirement could help CMS, Part D plans, and the Medicare program integrity contractor enhance their monitoring and better prevent and detect Part D improper payments and potential fraud.

Home-Based Services

Concerns with home-based services include fraud in home health, hospice, and the Personal Care Services (PCS) program.

Enforcement efforts, the capping of outlier payments, and imposing moratoria have significantly decreased illegal billing for home health services.[10] Schemes nonetheless continue to evolve, vulnerabilities persist, and home health remains a top oversight priority for OIG. Home health schemes often involve patient recruiters, co-conspirator beneficiaries receiving kickbacks, and HHAs billing but providing no care and/or unnecessary services. In one case, an HHA fraud scheme included company owners, health care providers, and patient recruiters conspiring to bill Medicare for services that were never rendered and that were for patients who were not

[9] Federal Register, Volume 79, Number 7, pages 1982-1987, published January 10, 2014, available at http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf.
[10] See Appendix 1, slide titled *Outcomes: HHA Payment Trends.*

homebound. The egregious behavior also included kickbacks to patients that included cash and the promise of prescriptions for narcotics. One of the HHA owners was sentenced to 10 years in prison and ordered to pay more than $10 million in restitution with his co-conspirators. One subject is still a fugitive at large.

OIG has also uncovered documentation errors and other vulnerabilities that are of concern in home health. For example, physicians (or certain practitioners working with them) who certify beneficiaries as eligible for Medicare home health services must document – as a condition of payment for home health services – that face-to-face encounters with those beneficiaries occurred. The face-to-face encounter alone does not satisfy the requirement; the certifying physician must also complete documentation that is clearly titled, signed, and dated. A recent OIG review reveals that for 32 percent of home health claims that required face-to-face encounters, the documentation did not meet Medicare requirements, resulting in $2 billion in payments that should not have been made.[11]

As of February 29, 2012, 2,004 HHAs still owed CMS a total of approximately $408 million for $590 million in overpayments that the agency identified for these HHAs between 2007 and 2011. CMS could have recovered at least $39 million between 2007 and 2011 if it had required each HHA to obtain a $50,000 surety bond.[12]

Key OIG recommendations include:

- Increase monitoring of Medicare claims for home health services.
- Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements.
- Implement the surety bond requirement for HHAs.[13]

Medicare's hospice benefit is designed for Part A patients who have been certified as terminally ill. It covers palliative and support services including personal care, medical equipment, therapy, and other services. Fraud in this area includes falsely certifying that patients are eligible for hospice services when they are not, and upcoding. Continuous home care (CHC) is a higher level of care meant for patients in crisis. Hospice fraud schemes involve billing CHC for patients who do not need this level of care and do not receive it, even back-dating a deceased patient's file to include CHC that was never provided. In one case, a hospice company owner billed Medicare over 16 million dollars for patients who were not hospice eligible, and for higher level care services than were provided. Doctors were paid for referrals for ineligible patients while nurses and other staff co-conspirators altered patient records to fabricate a decline in patient medical conditions. Sometimes patients receive cash kickbacks and are complicit in hospice fraud schemes, while other beneficiaries are unaware that they have been falsely

[11] *Limited Compliance With Medicare's Home Health Face to Face Documentation Requirements*, available at http://oig.hhs.gov/oei/reports/oei-01-12-00390.asp.

[12] *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments,* available at http://oig.hhs.gov/oei/reports/oei-03-12-00070.asp.

[13] In January 1998, CMS promulgated a final rule requiring each HHA to obtain a surety bond in the amount of $50,000 or 15 percent of the annual amount paid to the HHA by Medicare, whichever is greater. However, this regulation remains unimplemented.

categorized as hospice eligible. In another case, a hospice company owner conspired with an individual who provided names and identifying information of Medicare beneficiaries in exchange for cash; the signatures of referring physicians and Medicare beneficiaries were then forged on medical documents. OIG reviews also suggest that Medicare's hospice payment methodology may lead some hospices to inappropriately seek out beneficiaries in nursing facilities.[14]

Key OIG recommendations include:

- Monitor hospices that depend heavily on nursing facility residents.
- Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary.

The Medicaid Personal Care Services (PCS) program assists the elderly, those with disabilities, and those with chronic conditions with health care that they can receive while remaining in their homes. The services are provided by a personal care attendant (PCA). In 2011 alone, the PCS program spent $12.7 billion. Fraud in this program is increasing and includes schemes where PCAs and beneficiaries act as co-conspirators and care isn't needed or isn't provided. As of the first quarter of 2013, the State Medicaid Fraud Control Units had more than 1,000 such investigations nationwide. This fraud is very difficult to detect, often coming to our attention through whistleblowers. In one case, an individual who was on Medicaid disability herself, fraudulently signed up as a PCA. To avoid losing her own Medicaid benefits, the individual first misappropriated her daughter's name, and then conspired with a neighbor to use his name to obtain status as a PCA. The individual became the PCA to a family friend who was a Medicaid beneficiary. The individual ignored the patient's serious medical issues which should have led to hospitalization and the patient died from malnutrition and sepsis because of neglect. The individual was sentenced to 4 years of incarceration and the co-conspirator neighbor was sentenced to six months in prison.

Key OIG recommendations include:

- Consider whether additional controls are needed to ensure that the PCS are allowed under the program rules and are provided.
- Take action to provide States with data suitable for identifying overpayments for PCS claims when beneficiaries are receiving institutional care being paid for by Medicare or Medicaid.

Oversight Challenges

Data challenges and resource constraints pose significant challenges for program integrity efforts.

[14] *Medicare Hospices That Focus on Nursing Facility Residents*, available at http://oig.hhs.gov/oei/reports/oei-02-10-00070.asp.

Technology is Driving Changes in Program Integrity Efforts

Advances in data analysis and the proliferation of electronic health records (EHR) have changed the way OIG detects and investigates health care fraud. With the proliferation of EHR systems, we hope to see an increase in legibility and portability, more accurate billing, and improved quality of care. However, health care fraud itself has become more sophisticated as criminals use technology, including EHRs, to facilitate fraud. This has already been observed in the illegitimate use of cut-and-paste record cloning and over-documentation with false and irrelevant material to justify upcoding.

Additionally, with the growing use of EHR systems, evidence collection is moving increasingly away from paper files to an unprecedented amount of electronic evidence. As a result, law enforcement is developing new investigative techniques to supplement the traditional methods used in examining the authenticity and accuracy of records. We confront additional challenges relating to the collection and analysis of unprecedented amounts of electronic evidence. For example, the amount of digital data collected by OIG's Office of Investigations has grown ten-fold since 2009. While such advances have the potential to provide OIG and its law enforcement partners with more leads to investigate than ever before, the data deluge strains electronic server capacity and staff resources.

Additional Safeguards Are Needed to Protect Electronic Health Records

New digital environments also necessitate new safeguards for patient data. Yet through a survey of hospitals that received EHR incentive payments, OIG learned that not all recommended fraud safeguards have been implemented in hospital EHR technology.[15] For example, nearly half of hospitals indicated they could delete audit logs, and a third of hospitals indicated that they could disable their audit logs. Audit functions, such as audit logs, track access and changes within a record chronologically by capturing data elements, such as date, time, and user stamps, for each update to an EHR. An audit log can be used to analyze historical patterns that can identify data inconsistencies. To provide the most benefit in fraud protection, audit logs should always be operational while the EHR is being used and be stored as long as clinical records. Users should not be able to alter or delete the contents of the audit log. Deleting or disabling audit logs makes it harder to prevent and detect fraud. Further, most hospitals did not analyze audit logs with the intent to try to identify duplicate and fraudulent claims and inflated billing. In a separate review, we discovered that CMS and its contractors had not adjusted their program integrity strategies for electronic records versus paper records.[16]

Key OIG recommendations include:

- Mandate the use of the audit log feature in all EHRs.

[15] *Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology*, available at http://oig.hhs.gov/oei/reports/oei-01-11-00570.asp.

[16] *CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs*, available at http://oig.hhs.gov/oei/reports/oei-01-11-00571.asp.

- Work with contractors to identify best practices and develop guidance and tools for detecting fraud associated with EHRs, with specific guidance to address EHR documentation and electronic signatures in EHRs.

Oversight of Medicare and Medicaid is Hampered By Lack of Accurate, Timely, Complete Data

Data challenges manifest not only with respect to EHRs, but in other parts of Medicare and Medicaid. OIG is combining field intelligence with data mining, predictive analytics, and modeling to more efficiently target oversight, support ongoing investigations, and pursue shifts in health care fraud patterns. However, oversight of Medicare Part C (Medicare Advantage, or MA) and Medicare Part D is hampered by a lack of accurate, timely, and complete data that would facilitate oversight efforts. For example, MA and Part D plans' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the Parts C and D programs. Since 2008, OIG has repeatedly recommended that CMS require mandatory reporting of fraud and abuse data by MA and Part D plans. CMS has disagreed and therefore does not require mandatory reporting of fraud and abuse by these plans. Under the current voluntary reporting system, less than half of Part D plans reported fraud and abuse data to CMS. Twenty-eight percent of plans that identified fraud reported initiating no inquiries or corrective actions with regard to any of the incidents.[17]

Further, barriers exist to obtaining Medicare Part C claims data. CMS contracts with private organizations under Part C to provide private health plan managed care options. There is limited data availability and there are difficulties with access to information. There is no centralized Part C data repository, which hinders the ability to identify and investigate Part C fraud. Also the Medicare Drug Integrity Contractor is unable to share specific information with other program integrity contractors.

National-level oversight of Medicaid is similarly impeded by the lack of timely, accurate, and complete Medicaid data. OIG has uncovered significant shortcomings in the data available to conduct efficient, national Medicaid program integrity oversight through data analysis and data mining. While CMS has taken steps to improve Medicaid data through the Transformed Medicaid Statistical Information System, or T-MSIS, our review of early T-MSIS implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation.[18]

Key OIG recommendations include:

- Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to incidents of potential fraud and abuse.

[17] Testimony of Robert Vito, Regional Inspector General for Evaluation and Inspections, before House Committee on Energy and Commerce, March 4, 2014, available at http://oig.hhs.gov/testimony/docs/2014/vito_testimony_03042014.pdf.

[18] *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System*, available at http://oig.hhs.gov/oei/reports/oei-05-12-00610.asp.

- Establish a deadline for when complete, accurate, and timely T-MSIS data will be available.

Improvements Are Needed to States' Reporting to OIG of Adverse Actions Against Providers

One of the key administrative tools OIG utilizes is the authority to exclude individuals and entities from participating in the Federal health care programs. Like debarment in government procurement, the effect of an exclusion is that the excluded individual or entity cannot submit claims for services provided to Federal health care program beneficiaries. OIG receives important information from State licensing boards' notices of adverse actions, which enable us to identify numerous individuals who are subject to exclusion. However, we do not receive reports of all adverse actions from all States. State licensing boards are not statutorily required to refer adverse actions against providers to OIG. We currently receive this information on a voluntary basis from the State boards, general public notices of board actions in various States, or working relationships developed by OIG exclusions analysts with staff from various other agencies and organizations. Furthermore, the manner and timing of the notices is entirely dependent on each State licensing board. More reliable and standardized reporting from States would improve OIG's ability to exclude problematic providers.

Key OIG recommendations include:

- Explore requirements to increase and standardize State licensure boards' reporting of adverse actions to OIG.

Conclusion

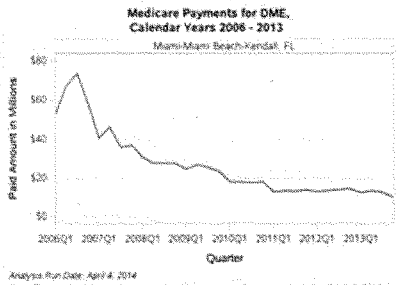
OIG is responsible for oversight of about 25 cents of every Federal dollar. Our oversight priorities extend not only to safeguarding Federal dollars but also to quality of care consequences for the programs and patients. As noted throughout my testimony, health care fraud is not just about dollars lost – health care fraud can also put patients' health at risk. Unfortunately OIG's mission is challenged by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. Since 2012, we have closed over 2,200 investigative complaints because of lack of resources. We expect to reduce our Medicare and Medicaid oversight by about 20 percent by the end of this FY. Yet the Department estimated that Medicare and Medicaid outlays would grow by about 20 percent from 2012 to 2014. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect the Medicare and Medicaid programs, beneficiaries, and taxpayers.

Thank you for your interest and support and for the opportunity to discuss some of our work. I am happy to answer any questions you may have.

APPENDIX I

Outcomes: DME Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

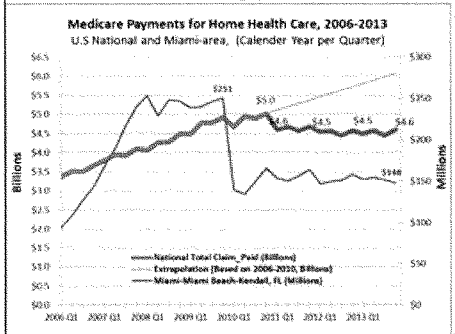


- Medicare payments for DME in Miami peaked at more than $60 million per quarter in 2006
- In 2007, numerous federal oversight and administrative initiatives were launched by CMS, OIG and others, including the Medicare Fraud Strike Force in May 2007
- Miami-area DME payments decreased from over $40 million per quarter in 2007 -*before the Strike Force's first takedown*- to $15 million per quarter in 2011 (e.g., approximately **$100 million** in annual savings thereafter)

1

Outcomes: HHA Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

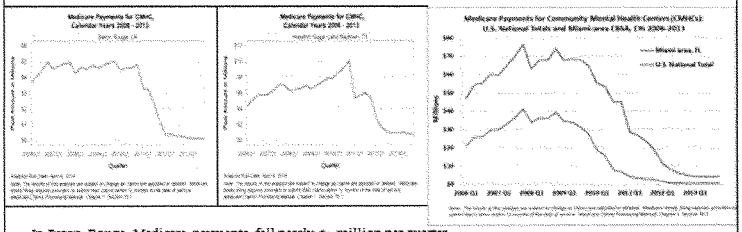


- **Medicare payments for Home Health care increased from 2006 until 2010**
- In 2009, federal enforcement actions (initiated by the HEAT Strike Force case *U.S. v. Zambrana* in Miami), followed by the OEI HHA Outlier Payments report, influenced CMS to change Medicare's HHA outlier coverage policy
- Since 2010, Medicare payments for home health care nationally decreased by more than $300 million per quarter (e.g., more than **$1 billion annually**)
  - In **Miami**, payments for HHAs decreased by $100 million per quarter since peak in 2009
  - In **Dallas and McAllen, TX**, payments for HHAs are down by $30 million per quarter
  - In **Detroit**, payments for HHAs decreased by $25 million per quarter since peak in 2009

2

Outcomes: CMHC Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.



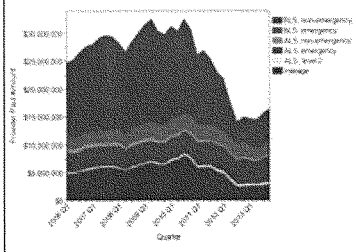
- In Baton Rouge: Medicare payments fell nearly $5 million per quarter
- In Houston: Medicare payments fell nearly $10 million per quarter
- In Miami: Medicare payments declined about $40 million per quarter
- **Nationally**, payments for CMHCs decreased from $70 million to under $5 million per quarter (>$250 **million annually**)

3

Outcomes: Ambulance Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

Houston Ambulance $



- Total Medicare payments for ambulance services (mostly for *BLS non-emergency* transports and *mileage*) in Houston are ***down approximately*** 50% from $32 million to $16 million per quarter since 2010
- The **Houston Chronicle** published article about high numbers of "private" ambulance companies and Medicare payments in October 2011
- Numerous **Medicare Fraud Strike Force** cases involving fraudulent ambulance claims filed in May 2012
- CMS announced six-month "moratorium" to halt enrollment of Houston-area ambulance providers in July 2013 (extended another six-months in January 2014)
- **American Taxpayer Relief Act of** 2012 reduced by 10% fee schedule payments for non-emergency BLS transports of individuals with End-Stage Renal Disease (ESRD) to and from renal dialysis treatment effective October 2013

4

Mr. MURPHY. Thank you. Ms. Jarmon, I don't think you have a statement, do you?

Ms. JARMON. No.

Mr. MURPHY. Ms. King, do you have a statement? Thank you. You are recognized for 5 minutes.

STATEMENT OF KATHLEEN M. KING

Ms. KING. I do. Chairman Murphy, Ranking Member DeGett,e and members of the subcommittee, thank you for inviting me to talk about our work regarding Medicare fraud, waste, and abuse. CMS has made progress in implementing several recommendations we identified through our work to help protect Medicare from fraud and improper payments. But there are additional actions they should take.

I want to focus my remarks today on three areas: provider enrollment, pre- and post-payment claims review and addressing vulnerabilities to fraud.

With respect to provider enrollment, CMS has implemented provisions of the Patient Protection and Affordable Care Act to strengthen the enrollment process so that potentially fraudulent providers are prevented from enrolling in Medicare and higher risk providers undergo more scrutiny before being permitted to enroll.

CMS has recently imposed moratoria on the enrollment of certain types of providers in fraud hotspots and has contracted for fingerprint-based background checks for high-risk providers. These are positive steps.

However, CMS has not completed certain actions authorized in PPACA which would also be helpful in fighting fraud. It has not yet published regulations to require additional disclosures of information regarding actions taken against providers such as payment suspensions, and it has not published regulations establishing the core elements of compliance programs or requirements for surety bonds for certain types of at-risk providers, including home health agencies.

With respect to review of claims for payment, Medicare uses prepayment review to deny payment for claims that should not be paid and post-payment review to recover improperly paid claims. Prepayment reviews are typically automated edits in claims processing systems that can prevent payment of improper claims. Post-payment reviews are those that are made after the fact and recover payments. We have found some weaknesses in the use of pre-payment edits and have made a number of recommendations to CMS to promote the implementation of effective edits regarding national policies and to encourage more widespread use of local pre-payment edits by Medicare administrative contractors.

With respect to post-payment claims review, we recently completed work that recommended greater consistency in the requirements under which four post-payment review contractors operate when it can be done without reducing the efforts to reduce improper payments. CMS agreed with our recommendations and is taking steps to implement them.

We also recommended to CMS that they collect and evaluate how quickly one type of post-payment review contractor, the Zone Pro-

gram Integrity Contractors, or ZPICS, takes action against suspect providers. CMS did not comment on this recommendation.

We also have further work underway on the post-payment review contractors to examine whether CMS has strategies to coordinate their work and whether these contractors comply with CMS's requirements regarding communications with providers.

With respect to vulnerabilities to fraud, we have made recommendations to CMS over the last several years, and CMS has implemented several of them, including establishing a single vulnerability tracking process and requiring the MACs to report on how they have addressed vulnerabilities. However, CMS has not taken action to address our recommendations to remove Social Security numbers from Medicare cards because display of these numbers increases beneficiaries' vulnerability to identity theft. We continue to believe that CMS should act on our recommendations, and we are currently studying the use of electronic card technologies, such as smart cards, for Medicare cards, including potential benefits and limitations and barriers to implementation.

Because Medicare is such a large and complex program, it is vulnerable to fraud and abuse. Constant vigilance is required to prevent, detect and deter fraud so that Medicare can continue to meet the needs of its beneficiaries.

I would be happy to answer questions. Thank you.

[The prepared statement of Ms. King follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. ET
Wednesday, June 25, 2014

MEDICARE FRAUD

Further Actions Needed to Address Fraud, Waste, and Abuse

Statement of Kathleen M. King
Director, Health Care

GAO Highlights

Highlights of GAO-14-712T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

June 25, 2014

MEDICARE FRAUD

Further Actions Needed to Address Fraud, Waste, and Abuse

Why GAO Did This Study

GAO has designated Medicare as a high-risk program, in part because the program's size and complexity make it vulnerable to fraud, waste, and abuse. In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion. The deceptive nature of fraud makes its extent in the Medicare program difficult to measure in a reliable way, but it is clear that fraud contributes to Medicare's fiscal problems. More broadly, in fiscal year 2013, CMS estimated that improper payments—some of which may be fraudulent—were almost $50 billion.

This statement focuses on the progress made and important steps to be taken by CMS and its program integrity contractors to reduce fraud in Medicare. This statement is based on relevant GAO products and recommendations issued from 2004 through 2014 using a variety of methodologies. Additionally, in June 2014, GAO updated information based on new regulations regarding enrollment of certain providers in Medicare by examining public documents.

View GAO-14-712T. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that oversees Medicare—has made progress in implementing several key strategies GAO identified or recommended in prior work as helpful in protecting Medicare from fraud; however, implementing other important actions that GAO recommended could help CMS and its program integrity contractors combat fraud. These strategies are:

Provider and Supplier Enrollment: The Patient Protection and Affordable Care Act (PPACA) authorized, and CMS has implemented, actions to strengthen provider and supplier enrollment that address past weaknesses identified by GAO and HHS's Office of Inspector General. For example, CMS has hired contractors to determine whether providers and suppliers have valid licenses and are at legitimate locations. CMS could further strengthen enrollment screening by issuing a rule to require additional provider and supplier disclosures of information, such as any suspension of payments from a federal health care program, and establishing core elements for provider and supplier compliance programs, as authorized by PPACA.

Prepayment and Postpayment Claims Review: Medicare uses prepayment review to deny claims that should not be paid and postpayment review to recover improperly paid claims. GAO has found that increased use of prepayment edits could help prevent improper Medicare payments. For example, prior GAO work identified millions of dollars of payments that appeared to be inconsistent with selected coverage and payment policies and therefore improper. Postpayment reviews are also critical to identifying and recouping overpayments. GAO recommended better oversight of both (1) the information systems analysts use to identify claims for postpayment review, in a 2011 report, and (2) the contractors responsible for these reviews, in a 2013 report. CMS has taken action or has actions under way to address these recommendations.

Addressing Identified Vulnerabilities: Having mechanisms in place to resolve vulnerabilities that could lead to improper payments is critical to effective program management and could help address fraud. However, prior GAO work has shown weaknesses in CMS's processes to address such vulnerabilities. For example, GAO has made multiple recommendations to CMS to remove Social Security numbers from beneficiaries' Medicare cards to help prevent identity theft. HHS agreed with these recommendations, but reported that CMS could not proceed with the changes for a variety of reasons, including funding limitations, and therefore has not taken action.

GAO work under way addressing these key strategies includes examining: (1) how well CMS's information system can prevent and detect the continued enrollment of ineligible or potentially fraudulent providers and suppliers in Medicare, (2) the potential use of electronic-card technologies to help reduce Medicare fraud, (3) CMS's oversight of program integrity efforts for prescription drugs, and (4) CMS's oversight of some of the contractors that conduct reviews of claims after payment. These studies could help CMS more systematically reduce potential fraud in the Medicare program.

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee:

I am pleased to be here today to discuss our work examining fraud in the Medicare program.[1] We have designated Medicare as a high-risk program since 1990, in part because we found the program's size and complexity make it vulnerable to fraud, waste, and abuse.[2] Although there have been convictions for multimillion-dollar schemes that defrauded the Medicare program, the extent of the problem is unknown.[3] There are no reliable estimates of the extent of fraud in the Medicare program or for the health care industry as a whole. By its very nature, fraud is difficult to detect, as those involved are engaged in intentional deception. For example, a provider submitting a fraudulent claim may include false documentation to substantiate a service not provided, and thus the claim may appear valid on its face. Fraud may also involve payments made to beneficiaries to obtain their Medicare number for fraudulent billing purposes. Although the full extent of the problem is unknown, it is clear that, as one of the largest programs in the federal government, the Medicare program is vulnerable to fraud, contributing to its fiscal problems.

In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion and reported some of the largest estimates of improper payments among federal programs—payments that either were made in an incorrect amount or should not

[1]Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.

[2]In 1990, we began to report on government operations that we identified as "high risk" for serious weaknesses in areas that involve substantial resources and provide critical services to the public. Medicare has been included among such programs since 1990. See GAO, *High-Risk Series: An Update*, GAO-13-283 (Washington, D.C.: February 2013).

[3]Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain.

have been made at all.[4] The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has estimated that improper payments in the Medicare program were almost $50 billion in fiscal year 2013, about $5 billion higher than in 2012.[5] Improper payments may be a result of fraud, waste, or abuse, but it is important to distinguish that the $50 billion in estimated improper payments reported by CMS in fiscal year 2013 is not an estimate of fraud in Medicare.[6] Reported improper payment estimates include many types of payments that should not have been made or were made in an incorrect amount such as overpayments, underpayments, and payments that were not adequately documented.

Since its inception, Medicare has been administered largely by contractors with federal oversight, and these contractors have a responsibility to help ensure Medicare program integrity.[7] CMS must oversee their efforts to help ensure proper payments and address the program's many vulnerabilities, which include service- or system-specific weaknesses that can lead to payment errors, including those due to

[4]Improper payments may be a result of fraud, waste, or abuse. They are any payments that should not have been made or that were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

[5]A list of abbreviations used in this statement is provided in app. I.

[6]Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

[7]The Medicare program consists of four parts: A, B, C, and D. Medicare Parts A and B are known as Medicare fee-for-service (FFS). Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D, either as a stand-alone benefit or as part of a Medicare Advantage plan. Contractors are responsible for administering Medicare FFS claims and conducting activities to reduce improper payments.

fraud.[8] If CMS suspects that providers or suppliers are billing fraudulently, it can take action through its contractors, including suspending claims payment, revoking billing privileges, or referring cases to law enforcement for investigation.[9]

My statement today focuses on the progress made and important steps to be taken by CMS to reduce fraud in Medicare. It is primarily based on our Medicare program integrity products issued and recommendations made from April 2004 through May 2014,[10] as well as selected updates on actions CMS has taken, and will focus on progress related to three key strategies we have identified as important to reducing fraud, waste, and abuse, and ultimately improper payments:[11]

- strengthening provider and supplier enrollment standards and procedures,
- improving prepayment and postpayment review of claims, and
- addressing identified vulnerabilities.

In June 2014, we updated information based on new regulations regarding enrollment of certain providers in Medicare by examining public documents. Our work for this statement and the products on which it was based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the

[8]CMS defines vulnerabilities to the Medicare program as issues that can lead to fraud, waste, or abuse, which can be either specific, such as providers receiving multiple payments as a result of incorrect coding for a service, or general and programwide, such as weaknesses in online application processes. An example of a vulnerability that leads to improper payments is providers billing for more than one blood transfusion in a hospital outpatient setting for a Medicare beneficiary in a day, which Medicare policy does not allow.

[9]In this testimony, the term *provider* includes entities such as hospitals or physicians, and *supplier* means entities such as ambulance service providers, mammography centers, and entities that supply Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), such as walkers and wheelchairs. This testimony will use the term providers and suppliers when referring to all Medicare providers and suppliers but will specify other suppliers, such as DMEPOS suppliers, when necessary.

[10]The products listed at the end of this statement contain detailed information on the various methodologies used in our work.

[11]See GAO, *Program Integrity: Further Action Needed to Address Vulnerabilities in Medicaid and Medicare Programs*, GAO-12-803T (Washington, D.C.: June 7, 2012).

audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Since 1996, Congress has taken important steps to increase Medicare program integrity funding and oversight, including the establishment of the Medicare Integrity Program. Table 1 summarizes several key congressional actions.

Table 1: Key Congressional Actions to Increase Medicare Program Integrity Funding and Oversight

Year	Congressional action	Statute
1996	Created the Medicare Integrity Program and established dedicated funding for activities to address fraud, waste, and abuse in federal health care programs, including Medicare[a]	Health Insurance Portability and Accountability Act of 1996[b]
2003	Directed CMS to conduct a 3-year demonstration project on the use of recovery audit contractors (RAC) for identifying and recouping Medicare underpayments and overpayments	Medicare Prescription Drug, Improvement, and Modernization Act of 2003[c]
2006	Required CMS to implement a national RAC program by January 1, 2010	Tax Relief and Health Care Act of 2006[d]
2010	Provided additional funding for program integrity activities and, among other things • established new provider enrollment requirements • required CMS to extend the Medicare RACs to Parts C and D of the Medicare program • required CMS to develop core elements for provider compliance programs • authorized surety bond requirements for certain Medicare providers[e]	Patient Protection and Affordable Care Act (PPACA)[f]
2010	Required Medicare fee-for-service to begin using predictive analytics to identify and prevent fraud[g]	Small Business Jobs Act of 2010[h]

Source: GAO analysis of selected federal laws. | GAO-14-712T

[a]The fund is known as the Health Care Fraud and Abuse Control account.

[b]Pub. L. No. 104-191, §§ 201(b)-202, 110 Stat. 1936, 1993-98 (codified at 42 U.S. C. §§ 1395i(k), 1395ddd).

[c]Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57.

[d]Pub. L. No. 109-432, div B., title III, § 302, 120 Stat. 2922, 2991-92 (codified at 42 U.S.C. § 1395 ddd(h)).

[e]A surety bond is a three-party agreement in which a company, known as a surety, agrees to compensate the bondholder if the bond purchaser fails to keep a specified promise.

[f]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[g]Predictive analytics include the use of algorithms and models to analyze claims before payment is made in order to identify unusual or suspicious patterns or abnormalities in provider networks, claims billing patterns, and beneficiary utilization.

[h]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.

CMS Has Strengthened Provider and Supplier Screening, but More Can Be Done to Improve Medicare Program Integrity

CMS has made progress in strengthening provider and supplier enrollment provisions, but needs to do more to identify and prevent potentially fraudulent providers and suppliers from participating in Medicare. Additional improvements to prepayment and postpayment claims review would help prevent and recover improper payments. Addressing payment vulnerabilities already identified could further help prevent or reduce fraud.

CMS Has Strengthened Certain Enrollment Screening Procedures since PPACA

PPACA authorized and CMS has implemented new provider and supplier enrollment procedures that address past weaknesses identified by GAO and HHS's Office of Inspector General (OIG) that allowed entities intent on committing fraud to enroll in Medicare. CMS has also implemented other measures intended to improve existing procedures. Specifically, to strengthen the existing screening activities conducted by CMS contractors, the agency added screenings of categories of provider and supplier enrollment applications by risk level, contracted with new national enrollment screening and site visit contractors, began imposing moratoria on new enrollment of certain types of providers and suppliers, and issued regulations requiring certain prescribers to enroll in Medicare.

Screening Provider and Supplier Enrollment Applications by Risk Level

CMS and OIG issued a final rule in February 2011 to implement many of the new screening procedures required by PPACA.[12] CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of Medicare providers and suppliers at each level. Providers and suppliers in the high-risk level are subject to the most rigorous screening.[13] (See table 2.) Based in part on our work and that of OIG, CMS designated newly enrolling home health agencies and

[12]*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011). In discussing the final rule, CMS noted that Medicare had already employed a number of the screening practices described in PPACA to determine whether a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.

[13]PPACA specified that the enhanced screening procedures apply to new providers and suppliers beginning 1 year after the date of enactment (March 23, 2010) and to currently enrolled providers and suppliers 2 years after that date.

suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as high risk, and designated other providers and suppliers as lower risk levels. Providers and suppliers at all risk levels are screened to verify that they meet specific requirements established by Medicare, such as having current licenses or accreditation and valid Social Security numbers.[14] High- and moderate-risk providers and suppliers are also subject to unannounced site visits. Further, depending on the risks presented, PPACA authorizes CMS to require fingerprint-based criminal history checks. In March 2014, CMS awarded a contract that is to enable the agency to access Federal Bureau of Investigation information to help conduct those checks of high-risk providers and suppliers. PPACA also authorizes the posting of surety bonds for certain providers and suppliers.[15]

Table 2: Categories of Medicare Providers and Suppliers Designated by Risk Level for Enrollment Screening

Risk level	Categories of Medicare providers and suppliers
Limited	Physician or nonphysician practitioners and medical groups or clinics, with the exception of physical therapists and physical therapy groups. Ambulatory surgical centers, competitive acquisition programs/Part B vendors, end-stage renal disease facilities, federally qualified health centers, histocompatibility laboratories,[a] hospitals including critical access hospitals, Indian Health Service facilities, mammography screening centers, mass immunization roster billers,[b] organ procurement organizations, pharmacies newly enrolling or revalidating, radiation therapy centers, religious nonmedical health care institutions, rural health clinics, and skilled nursing facilities.
Moderate	Ambulance suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent diagnostic testing facilities, independent clinical laboratories, physical therapy including physical therapy groups, portable X-ray suppliers, and currently enrolled (revalidating) home health agencies.
High	Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of durable medical equipment, prosthetics, orthotics, and supplies.

Source: GAO analysis of CMS regulations. | GAO-14-712T

[a]The responsibility of the histocompatibility laboratory is to provide an evaluation of certain genetic data and pertinent patient immunologic risk factors that will allow the clinician and patient to decide which approaches to transplantation are in the patient's best interest.

[b]Mass immunization roster billers are providers and suppliers who enroll in the Medicare program to offer the influenza (flu) vaccinations to a large number of individuals, and they must be properly licensed in the states in which they plan to operate influenza clinics.

[14]Screening may include verification of the following: Social Security number; National Provider Identifier (NPI); National Practitioner Databank licensure; whether the provider has been excluded from federal health care programs by OIG; taxpayer identification number; and death of an individual practitioner, owner, authorized official, delegated official, or supervising physician.

[15]A surety bond is a three-party agreement in which a company, known as a surety, agrees to compensate the bondholder if the bond purchaser fails to keep a specified promise.

CMS has indicated that the agency will continue to review the criteria for its screening levels and will publish changes if the agency decides to update the assignment of screening levels for categories of Medicare providers and suppliers. Doing so could become important because the Department of Justice (DOJ) and HHS reported multiple convictions, judgments, settlements, or exclusions against types of providers and suppliers not currently at the high-risk level, including community mental health centers and ambulance suppliers.[16] CMS's implementation of accreditation for DMEPOS suppliers, and of a competitive bidding program, including in geographic areas thought to have high fraud rates, may be helping to reduce the risk of DMEPOS fraud.[17] While continued vigilance of DMEPOS suppliers is warranted, other types of providers may become more problematic in the future. Specifically, in September 2012 we reported that a range of providers have been the subjects of fraud investigations.[18] According to 2010 data from OIG and DOJ, over 10,000 providers and suppliers that serve Medicare, Medicaid, and Children's Health Insurance Program beneficiaries were involved in fraud investigations, including not only home health agencies and DMEPOS suppliers but also physicians, hospitals, and pharmacies.[19] In addition, the provider type constituting the largest percentage of subjects in criminal health care fraud investigations was medical facilities—including medical centers, clinics, or practices—which constituted almost a quarter of subjects in such investigations. DMEPOS suppliers made up a little over 16 percent of subjects.

[16]Department of Health and Human Services and the Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (Washington, D.C.: February 2014).

[17]Competitive bidding is a process in which suppliers of medical equipment and supplies compete for the right to provide their products on the basis of established criteria, such as quality and price. See GAO, *Medicare: Second Year Update for CMS's Durable Medical Equipment Competitive Bidding Program Round 1 Rebid*, GAO-14-156 (Washington, D.C.: Mar. 7, 2014).

[18]GAO, *Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases*, GAO-12-820 (Washington, D.C.: Sept. 7, 2012).

[19]Medicaid is the federal-state program that covers acute health care, long-term care, and other services for certain low-income people. It is also one of the largest components of state budgets. Children's Health Insurance Program is the joint federal-state program that provides health coverage to children whose families have incomes that are low, but not low enough to qualify for Medicaid.

We are currently examining the ability of CMS's provider and supplier enrollment system to prevent and detect the continued enrollment of ineligible or potentially fraudulent providers and suppliers in Medicare. Specifically, we are assessing the process used to enroll and verify the eligibility of Medicare providers and suppliers in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) and the extent to which CMS's controls are designed to prevent and detect the continued enrollment of potentially ineligible or fraudulent providers and suppliers in PECOS. We plan to issue a report this winter.

Implementing National Enrollment Screening and Site Visit Contractors

CMS contracted with two new types of entities at the end of 2011 to assume centralized responsibility for two functions that had been the responsibility of multiple contractors. One of the new contractors is conducting automated screenings to check that existing and newly enrolling providers and suppliers have valid licensure, accreditation, and a National Provider Identifier (NPI), and are not on the OIG list of providers and suppliers excluded from participating in federal health care programs. The second contractor conducts site visits of providers and suppliers, except for DMEPOS suppliers, to determine whether sites are legitimate and the providers and suppliers meet certain Medicare standards.[20] A CMS official reported that, since the implementation of the PPACA screening requirements, the agency had revoked over 17,000 suspect providers' and suppliers' ability to bill the Medicare program.[21]

Establishing Moratoria on Enrollment of New Providers and Suppliers in Certain Areas

CMS has suspended enrollment of new home health providers and ground ambulance suppliers in certain fraud "hot spots" and other geographic areas. In July 2013, CMS first exercised its authority granted by PPACA to establish temporary moratoria on enrolling new home health agencies in Chicago and Miami, and new ambulance suppliers in Houston.[22] In January 2014, CMS extended its first moratoria and added

[20]Site visits for DMEPOS suppliers are to continue to be conducted by the contractor responsible for their enrollment. In addition, CMS at times exercises its authority to conduct a site visit or request its contractors to conduct a site visit for any Medicare provider or supplier.

[21]S. Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, *Preventing Medicare Fraud: How Can We Best Protect Seniors and Taxpayers?*, testimony before the Senate Special Aging Committee, 113th Cong., 2nd sess., March 26, 2014.

[22]Under the moratoria, existing providers and suppliers can continue to deliver and bill for services, but no new provider and supplier applications will be approved in these areas. CMS re-evaluates the need for such moratoria every 6 months.

enrollment moratoria for new home health agency providers in Fort Lauderdale, Detroit, Dallas, and Houston, and new ambulance suppliers in Philadelphia. These moratoria are scheduled to be in effect until July 2014, unless CMS extends or lifts them. CMS officials cited areas of potential fraud risk, such as a disproportionate number of providers and suppliers relative to beneficiaries and extremely high utilization as rationales for suspending new enrollments of home health providers or ground ambulance suppliers in these areas.

Requiring Certain Prescribers to Enroll in Medicare

CMS recently issued a final rule requiring prescribers of drugs covered within Medicare's prescription drug program, Part D, to enroll in Medicare by June 2015.[23] As a result of this rule, CMS is to screen these prescribers to verify that they meet specific requirements, such as having current licenses or accreditation and valid Social Security numbers. OIG has identified concerns with CMS oversight of fraud, waste, and abuse in Part D, including the contractors tasked with this work. A June 2013 OIG report found that the Part D program inappropriately paid for drugs ordered by individuals who clearly did not have the authority to prescribe, such as massage therapists, athletic trainers, home contractors, and interpreters.[24] OIG recommended, among other things, that there should be verification of prescribers' authority to prescribe drugs, and that CMS should ensure that Medicare does not pay for prescriptions from individuals without such authority. CMS agreed with OIG's recommendations and, in discussing the final rule, stated that this new enrollment requirement is to help ensure that Part D drugs are prescribed only by qualified physicians and eligible professionals. To continue to help address potential vulnerabilities in the Part D program, we are currently examining practices for promoting prescription drug program integrity and the extent to which CMS's oversight of Medicare Part D reflects those practices. We plan to issue a report this fall.

[23]*Medicare Program: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs. 79 Fed. Reg. 29,844* (May 23, 2014).

[24]Department of Health and Human Services, Office of Inspector General, *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608 (June 21, 2013).

Additional Enrollment Screening Could Help Ensure Potentially Fraudulent Providers and Suppliers Do Not Participate in Medicare

Although CMS has taken many needed actions, we and OIG have found that CMS has not fully implemented other enrollment screening actions authorized by PPACA.[25] These actions could help further reduce the enrollment of providers and suppliers intent on defrauding the Medicare program, which is important because identifying and prosecuting providers and suppliers engaged in potentially fraudulent activity is time consuming, resource intensive, and costly. These actions include issuing a rule to implement surety bonds for certain providers and suppliers, issuing a rule on provider and supplier disclosure requirements, and establishing the core elements for provider and supplier compliance programs.

Surety Bonds

PPACA authorized CMS to require a surety bond for certain types of at-risk providers and suppliers. Surety bonds may serve as a source for recoupment of erroneous payments. DMEPOS suppliers are currently required to post a surety bond at the time of enrollment.[26] CMS reported in April 2014 that it had not yet scheduled for publication a proposed rule to implement the PPACA surety bond requirement for other types of at-risk providers and suppliers—such as home health agencies and independent diagnostic testing facilities. In light of the moratoria that CMS has placed on enrollment of home health agencies in fraud "hot spots," implementation of this rule could help the agency address potential concerns for these at-risk providers across the Medicare program.

Providers and Suppliers Disclosure

CMS has not yet scheduled a proposed rule for publication for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, as authorized by PPACA, such as whether the provider or supplier has been subject to a payment

[25]GAO, *Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers*, GAO-12-351 (Washington, D.C.: Apr. 10, 2012).

[26]42 U.S.C. § 1395m(a)(16)(B). A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, the surety bond is paid to Medicare. Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), 74 Fed. Reg. 166 (Jan. 2, 2009).

suspension from a federal health care program.[27] Agency officials had indicated that developing the additional disclosure requirements has been complicated by provider and supplier concerns about what types of information will be collected, what CMS will do with it, and how the privacy and security of this information will be maintained.

Compliance Program

CMS has not established the core elements of compliance programs for providers and suppliers, as required by PPACA. We previously reported that agency officials indicated that they had sought public comments on the core elements, which they were considering, and were also studying criteria found in OIG model plans for possible inclusion.[28] As of April 2014, CMS reported that it had not yet scheduled a proposed rule for publication.

Further Improvements to Prepayment and Postpayment Claims Review May Better Identify or Recover Improper Payments

Medicare uses prepayment review to deny claims that should not be paid and postpayment review to recover improperly paid claims. As claims go through Medicare's electronic claims payment systems, they are subjected to prepayment controls called "edits," most of which are fully automated; if a claim does not meet the criteria of the edit, it is automatically denied.[29] Other prepayment edits are manual; they flag a claim for individual review by trained staff who determine whether it should be paid. Due to the volume of claims, CMS has reported that less

[27]At the time of initial enrollment or revalidation of enrollment, PPACA requires providers and suppliers to disclose, in a form and manner and at such time as determined by the Secretary, any current or previous affiliation with another provider or supplier that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or State Children's Health Insurance Program; or has had its billing privileges denied or revoked. Pub. L. No. 111-148, § 6401(a), 124 Stat. 119, 750 (2010).

[28]A compliance program is an internal set of policies, processes, and procedures that a provider organization implements to help it act ethically and lawfully. In this context, a compliance program is intended to help provider and supplier organizations prevent and detect violations of Medicare laws and regulations. OIG has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry, such as hospitals, nursing homes, third-party billers, and durable medical equipment suppliers, to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements.

[29]Edits are instructions programmed in the systems to prevent payment of incomplete or incorrect claims. Some edits use provider enrollment information, while others use information on coverage or payment policies, to determine whether claims should be paid.

than 1 percent of Medicare claims are subject to manual medical record review by trained personnel.

Increased use of prepayment edits could help prevent improper Medicare payments. Our prior work found that, while use of prepayment edits saved Medicare at least $1.76 billion in fiscal year 2010, the savings could have been greater had prepayment edits been used more widely.[30] Based on an analysis of a limited number of national policies and local coverage determinations (LCD), we identified $14.7 million in payments in fiscal year 2010 that appeared to be inconsistent with four national policies and therefore improper.[31] We also found more than $100 million in payments that were inconsistent with three selected LCDs that could have been identified using automated edits. Thus, we concluded that more widespread implementation of effective automated edits developed by individual MACs in other MAC jurisdictions could also result in savings to Medicare. CMS has taken steps to improve the development of other types of prepayment edits that are implemented nationwide, as we recommended. For example, the agency has centralized the development and implementation of automated edits based on a type of national policy called national coverage determinations.[32] CMS has also modified its processes for identifying provider billing of services that are medically

[30]See GAO, *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, GAO-13-102 (Washington, D.C.: Nov. 13, 2012).

[31]Each Medicare administrative contractor (MAC) has the authority to develop LCDs that delineate the circumstances under which services are considered reasonable and necessary and are therefore covered in the geographic area where that MAC processes claims. These local policies cannot conflict with national coverage and payment policies established by CMS or by law. MACs' authority to develop LCDs leads to differences in Medicare coverage policy in different areas of the country. MACs may create prepayment edits either to implement their LCDs or to implement national Medicare policies set by CMS, although not every LCD or national policy is structured in a way that makes edit development feasible. CMS has responsibility for providing information and oversight to MACs with respect to their use of prepayment edits to promote effective stewardship of Medicare funds.

[32]CMS typically develops national coverage determinations for services that have the potential to affect a large number of beneficiaries and that have the greatest effect on the Medicare program. Development of national coverage determinations is a lengthy process, which requires review of clinical evidence and allows for public comment.

unlikely to prevent circumvention of automated edits designed to identify an unusually large quantity of services provided to the same patient.[33]

We also evaluated the implementation of CMS's Fraud Prevention System (FPS), which uses predictive analytic technologies as required by the Small Business Jobs Act of 2010 to analyze Medicare fee-for-service (FFS) claims on a prepayment basis. FPS identifies investigative leads for CMS's Zone Program Integrity Contractors (ZPIC), the contractors responsible for detecting and investigating potential fraud.[34] Implemented in July 2011, FPS is intended to help facilitate the agency's shift from focusing on recovering potentially fraudulent payments after they have been made, to detecting aberrant billing patterns as quickly as possible, with the goal of preventing these payments from being made. However, in October 2012, we found that, while FPS generated leads for investigators, it was not integrated with Medicare's payment-processing system to allow the prevention of payments until suspect claims can be determined to be valid. As of April 2014, CMS reported that while the FPS functionality to deny claims before payment had been integrated with the Medicare payment processing system in October 2013, the system did not have the ability to suspend payment until suspect claims could be investigated. In addition, while CMS directed the ZPICs to prioritize alerts generated by the system, in our work examining the sources of new ZPIC investigations in 2012, we found that FPS accounted for about 5 percent of ZPIC investigations in that year.[35] A CMS official reported in March 2014 that ZPICs are now using FPS as a primary source of leads for fraud investigations, though the official did not provide details on how much of ZPICs' work is initiated through the system.[36]

[33]CMS refers to these as Medically Unlikely Edits. These edits are designed to deny payment for services where the number of units billed exceeds the maximum number a provider would bill under most circumstances for a beneficiary on a single date of service.

[34]GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

[35]GAO, *Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight*, GAO-14-111 (Washington, D.C.: Oct. 25, 2013).

[36]S. Agrawal, *Preventing Medicare Fraud*, testimony before the Senate Special Aging Committee, March 26, 2014. Additionally, CMS has not published a report detailing the results of the second year of implementation of the FPS system, as required by the Small Business Jobs Act of 2010. The report was due in 2013.

Our prior work found that postpayment reviews are critical to identifying and recouping overpayments.[37] The use of national recovery audit contractors (RAC)[38] in the Medicare program is helping to identify underpayments and overpayments on a postpayment basis.[39] CMS began the program in March 2009 for Medicare FFS.[40] CMS reported that, as of the end of 2013, RACs collected $816 million for fiscal year 2014.[41] PPACA required the expansion of Medicare RACs to Parts C and D. CMS has implemented a RAC for Part D, and CMS said it plans to award a contract for a Part C RAC by the end of 2014. Moreover, in February 2014, CMS announced a "pause" in the RAC program as the agency makes changes to the program and starts a new procurement process for the next round of recovery audit contracts for Medicare FFS claims. CMS stated it anticipates awarding all five of these new Medicare FFS recovery audit contracts by the end of summer 2014.

Other contractors help CMS investigate potentially fraudulent FFS payments, but CMS could improve its oversight of their work. CMS contracts with ZPICs in specific geographic zones covering the nation. In October 2013, we found that the ZPICs reported that their actions, such as stopping payments on suspect claims, resulted in more than $250 million in savings to Medicare in calendar year 2012.[42] However, CMS lacks information on the timeliness of ZPICs' actions—such as the time it takes between identifying a suspect provider and taking actions to stop

[37]See GAO, *Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010).

[38]These contractors are also referred to as Recovery Auditors.

[39]Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about 40 years.

[40]The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed CMS to conduct a demonstration of the use of RACs in identifying underpayments and overpayments, and recouping overpayments in Medicare. Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57. Subsequently, the Tax Relief and Health Care Act of 2006 required CMS to implement a national RAC program by January 1, 2010. Pub. L. No. 109-432, div. B, title III, § 302, 120 Stat. 2922, 2991 (codified at 42 U.S.C. § 1395ddd(h)).

[41]See Centers for Medicare & Medicaid Services, *Medicare Fee for Service, National Recovery Audit Program, Quarterly Newsletter*, accessed Apr. 17, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-1st-qtr-2014.pdf.

[42]GAO-14-111.

that provider from receiving potentially fraudulent Medicare payments—and would benefit from knowing whether ZPICs could save more money by acting more quickly. Thus we recommended that CMS collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions. CMS did not provide comments on our recommendation. We are currently examining the activities of the CMS contractors, including ZPICs, that conduct postpayment claims reviews, and anticipate issuing a report later this summer. Our work is reviewing, among other things, whether CMS has a strategy for coordinating these contractors' postpayment claims review activities.

CMS has taken steps to improve use of two CMS information technology systems that could help analysts identify fraud after claims have been paid, but further action is needed. In 2011, we found that the Integrated Data Repository (IDR)—a central data store of Medicare and other data needed to help CMS program integrity staff and contractors detect improper payments of claims—did not include all the data that were planned to be incorporated by fiscal year 2010, because of technical obstacles and delays in funding.[43] As of March 2014, the agency had not addressed our recommendation, to develop reliable schedules to incorporate all types of IDR data, which could lead to additional delays in making available all of the data that are needed to support enhanced program integrity efforts and achieve the expected financial benefits. However, One Program Integrity (One PI)—a web-based portal intended to provide CMS staff and contractors with a single source of access to data contained in IDR, as well as tools for analyzing those data—is operational, and CMS has established plans and schedules for training all intended One PI users, as we also recommended in 2011. However, as of March 2014, CMS had not established deadlines for program integrity contractors to begin using One PI, as we recommended in 2011. Without these deadlines, program integrity contractors will not be required to use the system, and as a result, CMS may fall short in its efforts to ensure the widespread use and to measure the benefits of One PI for program integrity purposes.

[43]GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

Addressing Identified Vulnerabilities Could Help Reduce Fraud

Having mechanisms in place to resolve vulnerabilities that could lead to improper payments, some of which are potentially fraudulent, is critical to effective program management, but our work has shown weaknesses in CMS's processes to address such vulnerabilities.[44] Both we and OIG have made recommendations to CMS to improve the tracking of vulnerabilities. In our March 2010 report on the RAC demonstration program, we found that CMS had not established an adequate process during the demonstration or in planning for the national program to ensure prompt resolution of vulnerabilities that could lead to improper payments in Medicare; further, the majority of the most significant vulnerabilities identified during the demonstration were not addressed.[45] In December 2011, OIG found that CMS had not resolved or taken significant action to resolve 48 of 62 vulnerabilities reported in 2009 by CMS contractors specifically charged with addressing fraud.[46] We and OIG recommended that CMS have written procedures and time frames to ensure that vulnerabilities were resolved. CMS has indicated that it is now tracking vulnerabilities identified from several types of contractors through a single vulnerability tracking process, and the agency has developed some written guidance on the process. In 2012, we examined that process and found that, while CMS informs Medicare administrative contractors (MAC) about vulnerabilities that could be addressed through prepayment edits, the agency does not systematically compile and disseminate information about effective local edits to address such vulnerabilities.[47] Specifically,

[44]Federal internal control standards state that an agency should have policies and procedures to ensure that (1) the findings of all audits and reviews are promptly evaluated, (2) decisions are made about the appropriate response to these findings, and (3) actions are taken to correct or resolve the issues promptly. These are all aspects of internal control, which is the component of an organization's management that provides reasonable assurance that the organization achieves effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Internal control standards provide a framework for identifying and addressing major performance challenges and areas at greatest risk for mismanagement. See GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

[45]GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143 (Washington, D.C.: Mar. 31, 2010).

[46]Department of Health and Human Services, Office of Inspector General, *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500 (December 2011).

[47]GAO-13-102.

we recommended that CMS require MACs to share information about the underlying policies and savings related to their most effective edits, and CMS generally agreed to do so. In addition, in 2011 CMS began requiring MACs to report on how they had addressed certain vulnerabilities to improper payment, some of which could be addressed through edits.

We also made recommendations to CMS to address the millions of Medicare cards that display beneficiaries' Social Security numbers, which increases beneficiaries' vulnerability to identity theft.[48] In August 2012, we recommended that CMS (1) select an approach for removing Social Security numbers from Medicare cards that best protects beneficiaries from identity theft and minimizes burdens for providers, beneficiaries, and CMS; and (2) develop an accurate, well-documented cost estimate for such an option. In September 2013, we further recommended that CMS (1) initiate an information technology project for identifying, developing, and implementing changes for the removal of Social Security numbers; and (2) incorporate such a project into other information technology initiatives. HHS concurred with our recommendations and agreed that removing the numbers from Medicare cards is an appropriate step toward reducing the risk of identity theft. However, the department also stated that CMS could not proceed with changes without agreement from other agencies, such as the Social Security Administration, and that funding was also a consideration. Thus, CMS has not yet taken action to address these recommendations. We are currently examining other options for updating and securing Medicare cards, including the potential use of electronic-card technologies, and expect to issue a report early next year.

In conclusion, although CMS has taken some important steps to identify and prevent fraud through increased provider and supplier screening and other actions, the agency must continue to improve its efforts to reduce fraud, waste, and abuse in the Medicare program. Identifying the nature, extent, and underlying causes of improper payments, and developing adequate corrective action processes to address vulnerabilities, are essential prerequisites to reducing them. As CMS continues its implementation of PPACA and Small Business Jobs Act provisions,

[48]GAO, *Medicare Information Technology: Centers for Medicare and Medicaid Services Needs to Pursue a Solution for Removing Social Security Numbers from Cards*, GAO-13-761 (Washington, D.C.: Sept. 10, 2013) and GAO, *CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from Medicare Cards*, GAO-12-831 (Washington, D.C.: Aug. 1, 2012).

additional evaluation and oversight will help determine whether implementation of these provisions has been effective in reducing improper payments. We are investing resources in a body of work that assesses CMS's efforts to refine and improve its fraud detection and prevention abilities. Notably, we are currently assessing potential use of electronic-card technologies, which can help reduce Medicare fraud. We are also examining the extent to which CMS's information system can help prevent and detect the continued enrollment of ineligible or potentially fraudulent providers and suppliers in Medicare. Additionally, we have a study under way examining CMS's oversight of fraud, waste, and abuse in Medicare Part D to determine whether the agency has adopted certain practices for ensuring the integrity of that program. We are also examining CMS's oversight of some of the contractors that conduct reviews of claims after payment. These studies are focused on additional actions for CMS that could help the agency more systematically reduce potential fraud in the Medicare program.

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Karen Doran, Assistant Director; Eden Savino; and Jennifer Whitworth were key contributors to this statement.

Appendix I: Abbreviations

CMS	Centers for Medicare & Medicaid Services
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DOJ	Department of Justice
FFS	fee-for-service
FPS	Fraud Prevention System
HHS	Department of Health and Human Services
IDR	Integrated Data Repository
LCD	local coverage determination
MAC	Medicare administrative contractor
NPI	National Provider Identifier
OIG	Office of Inspector General
One PI	One Program Integrity
PECOS	Provider Enrollment, Chain, and Ownership System
PPACA	Patient Protection and Affordable Care Act
RAC	recovery audit contractor
ZPIC	Zone Program Integrity Contractor

Related GAO Products

Medicare: Further Action Could Improve Improper Payment Prevention and Recoupment Efforts. GAO-14-619T. Washington, D.C.: May 20, 2014.

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Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness. GAO-11-592. Washington, D.C.: July 29, 2011.

Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use. GAO-11-475. Washington, D.C.: June 30, 2011.

Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments. GAO-10-844T. Washington, D.C.: June 15, 2010.

Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight. GAO-10-143. Washington, D.C.: March 31, 2010.

Medicare: Thousands of Medicare Providers Abuse the Federal Tax System. GAO-08-618. Washington, D.C.: June 13, 2008.

Related GAO Products

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Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs. GAO-05-43. Washington, D.C.: November 17, 2004.

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Mr. MURPHY. Thank you. I thank all the witnesses. I will now begin some questions for 5 minutes. Dr. Agrawal, you need to know whether the agency's actions have been successful in reducing fraud and abuse, and one way that the agencies examine the effect on this is by measuring performance as required by the Government Performance and Results Act of 1993 as amended by the GPRA Modernization Act. One of CMS's goals is to fight fraud and work when they've made improper payment. Isn't that right?

Dr. AGRAWAL. We are absolutely focused on the improper payment rate and working to reduce that rate.

Mr. MURPHY. And isn't it correct that CMS's target improper payment rate for Medicare fee for service for fiscal year 2013 was 8.3 percent? Is that about what the target was?

Dr. AGRAWAL. Yes.

Mr. MURPHY. Now, that translates to about $36 billion in losses. So what I don't understand is why is it acceptable to have about a $36 billion loss rate that is acceptable?

Dr. AGRAWAL. I don't think it is about acceptability, sir. We are focused on the improper payment rate and reducing that rate as much as feasible.

I will say just two points on the improper payment rate. One is it is not equivalent to the fraud rate. Improper payments do not measure the amount of criminal behavior that is in the Medicare program. That is often an area of confusion I find among stakeholders. Second, what it really does I think show, demonstrate, is the ability of providers to follow our strict payment guidelines and requirements, namely and most particularly, documentation requirements. So we see for example areas where the improper payment rate continues to rise, like certain institutional providers, DME suppliers, home health services, and we do think——

Mr. MURPHY. It went up for 2013 for you to 10.7 percent, I think.

Dr. AGRAWAL. Well, I think what we have done is institute a lot more specific requirements in those areas in order to reduce fraud, waste and abuse. Those requirements can take time for providers to catch up with, and what we see is documentation lags and the improper payment rate goes up.

Mr. MURPHY. I guess I am concerned about that you went from 8.5 percent to 10.7 percent which says it is getting worse.

Dr. AGRAWAL. Again, I think it is an outcome of our more stringent requirements. I think this shows the balancing act between trying to be very strong on program integrity which is really enforced by strong rules and regulations and then those rules and regulations being difficult for providers to follow.

Mr. MURPHY. The bottom line up front, though, is you didn't meet your goals and it is getting worse.

Dr. AGRAWAL. Correct. Well, we did not meet our goal, and we have taken proactive steps to help reverse that trend. One is we work very closely with providers to help educate them on our rules to make sure that they are able to follow our rules, follow our documentation requirements. We have instituted point audits that allow us to look at specific——

Mr. MURPHY. I get all that. I am just saying bottom line for taxpayers is the amount of money that has been done in improper

payments is greater than the entire budget of the State of Pennsylvania. So I hope you will improve that.

Let me ask this. I am trying to find ways that can facilitate you on this because you are probably familiar with that old quote from the bank robber Willie Sutton why he robbed banks, and he says because that is where the money is. So with $600 billion in Medicare spending, that looks like a ripe target for a lot of people. But the fact that he was convicted as a bank robber, I believe the way the laws and regulations are written right now, those types of criminal convictions wouldn't prevent you from giving someone Medicare payments, am I correct? They could still slip through the system?

Dr. AGRAWAL. Certain convictions we can revoke from the Medicare program for——

Mr. MURPHY. Would bank robbery be one of them?

Dr. AGRAWAL. Felony convictions? So I am no lawyer. I assume bank robbery is a felony conviction.

Mr. MURPHY. A felony conviction.

Dr. AGRAWAL. If it is a felony conviction, then yes, we can kick people out of the Medicare program.

Mr. MURPHY. I just want to be sure. Mr. Cantrell, would you know if someone with some felony conviction—we are trying to improve this. So if it is not there, I would like to know. Insurance fraud, auto insurance fraud, tax fraud. I believe tax fraud is still acceptable, that they wouldn't be kicked out of the program. Do either of you know that?

Mr. CANTRELL. As it relates to our exclusion authority?

Mr. MURPHY. Yes.

Mr. CANTRELL. There are requirements that link it to in connection with the delivery of a healthcare item or service.

Mr. MURPHY. But if it is not healthcare. So if someone was involved with auto insurance fraud or assault or convicted of clinical research fraud, if it is not health, right, they can still be a Medicare provider, am I correct——

Dr. AGRAWAL. We have——

Mr. MURPHY [continuing]. The way the law is currently written?

Dr. AGRAWAL. We have very proscribed guidelines for what we can revoke for. They are four types of felony convictions.

Mr. MURPHY. I am trying to help you so——

Dr. AGRAWAL. These are not——

Mr. MURPHY. If you would like it stricter, we need to know this. So if someone has a history of criminal fraud, criminal felony behavior, and you can't exclude them, I think one of the best predictors of future problems is past. And if someone has a pattern of this, can they still slip through and be a provider for Medicare?

Dr. AGRAWAL. Yes, I think the agency agrees with you, sir. In fact, we have taken steps in the last year to put out a proposed rule that would actually expand our use of this felony conviction.

Mr. MURPHY. Well, we would like to work with you on that. Let me ask one other thing. Can someone with a foreign address or just a box number also be a Medicare provider? Do you go through and check those records?

Dr. AGRAWAL. We do check records. We have automated checks for addresses as well as the ability to conduct on-site visits to make sure that these are legitimate places of business.

Mr. MURPHY. Can someone with a foreign address be a Medicare provider?

Dr. AGRAWAL. I would have to check specifically on that, but I believe the answer is no.

Mr. MURPHY. OK. We will find out. Ms. DeGette, you are recognized for 5 minutes.

Ms. DEGETTE. Dr. Agrawal, in your testimony you discussed how taxpayers get a significant return on investments to reduce Medicare fraud, is that right?

Dr. AGRAWAL. Yes.

Ms. DEGETTE. And I have been told for each dollar we spend, we save more than a dollar. Is that right?

Dr. AGRAWAL. Yes.

Ms. DEGETTE. Why is that true?

Dr. AGRAWAL. Our activities are having impact. I think we have clearly——

Ms. DEGETTE. But why for each dollar that we spend do we save more than a dollar?

Dr. AGRAWAL. I think our activities have a cumulative effect, so they can actually prevent dollars from going out the door in the first place. They have sentinel effects where we see impact beyond just the specific providers and suppliers that we are looking at. I think all those things cumulatively lead to that higher ROI.

Ms. DEGETTE. It is a systemic issue?

Dr. AGRAWAL. Correct.

Ms. DEGETTE. OK. And what are the sources of funds for CMS program integrity efforts?

Dr. AGRAWAL. We have a variety of funds. We have both Medicare and Medicaid funds. We have Small Business Jobs Act funds that are connected, for example, to the FPS, HCFAC funds.

Ms. DEGETTE. How much will CMS spend this year on Medicare and Medicaid program integrity efforts?

Dr. AGRAWAL. I would have to come back to you with a specific number. I am not sure about——

Ms. DEGETTE. I would appreciate it——

Dr. AGRAWAL [continuing]. The total application——

Ms. DEGETTE [continuing]. If you would supplement your response.

Dr. AGRAWAL. Absolutely.

Ms. DEGETTE. Do you remember how much you spent in 2012?

Dr. AGRAWAL. No, ma'am.

Ms. DEGETTE. OK. Do you know if there has been an increase or a reduction in funding for fighting fraud over the last 2 years?

Dr. AGRAWAL. Well, we have experienced between the sequester and then sort of flat-funding is a general flattening out of our funding and that has forced us to make certain budgetary decisions about what programs and tools to focus on.

Ms. DEGETTE. Now, you mentioned the layoffs, and I talked about that in my opening statement. What other programmatic adjustments have you made?

Dr. AGRAWAL. Well, I might just point out that the layoffs most significantly impacted the Office of Inspector General——

Ms. DEGETTE. OK.

Dr. AGRAWAL [continuing]. Which we take seriously obviously as well.

Ms. DEGETTE. So Mr. Cantrell, maybe you can answer that.

Mr. CANTRELL. Sure. Our budget is primarily funded—our healthcare oversight is primarily funded by the Healthcare Fraud and Abuse Control Act, and that fund is—we get about $300 million a year. But with sequestration, it takes about $14 million out of that healthcare oversight fund. We have another funding stream that we call our discretionary fund that funds all of our other activity related to the Department of Health and Human Services but not the Medicare and Medicaid programs.

Ms. DEGETTE. Have you made programmatic adjustments to account for the budget cuts or have you just laid people off?

Mr. CANTRELL. We haven't laid people off. We have lost people through attrition.

Ms. DEGETTE. OK.

Mr. CANTRELL. We have reduced investments in things like training, equipment——

Ms. DEGETTE. Now you have fewer people doing the job.

Mr. CANTRELL. That is correct.

Ms. DEGETTE. Right?

Mr. CANTRELL. That is correct.

Ms. DEGETTE. So are you trying to make them figure out how to do the job more efficiently?

Mr. CANTRELL. We do. We are trying to focus our work on the areas where we can have the greatest impact. So the biggest thing we are doing is picking our work. There is much more work in this program than we have the ability to do. So we are being very strategic about the work that we select, and placing our resources in areas where they can have the greatest impact is our strategy here.

Ms. DEGETTE. So this is really a situation. If we adequately funded you, then you could actually do more investigations and pick more cases, correct?

Mr. CANTRELL. Absolutely.

Ms. DEGETTE. Now, for either one of you who knows the answer to this, while we have been having a slight reduction in the funding, at the same time, the Medicare population has increased and Medicare expenditures have increased. Is that correct, Dr. Agrawal?

Dr. AGRAWAL. That is correct.

Ms. DEGETTE. You know, Mr. Chairman, I think that there are some things you can do by efficiencies and by being smart and so on. But when you cut $30 million from CMS's integrity efforts, I am not sure how much you can make up for that.

Dr. Agrawal, the administration has asked for significant increase in program integrity funding for fiscal year 2015, over $400 million. Is that correct?

Dr. AGRAWAL. Yes.

Ms. DEGETTE. And what would you do with that funding?

Dr. AGRAWAL. That funding would really allow us to expand programs that we know have impact. As an example, our prior author-

ization demo could be expanded nationally into program areas that it doesn't currently cover. We know that that could have impact.

Ms. DEGETTE. Do you think that would assist you?

Dr. AGRAWAL. Absolutely.

Ms. DEGETTE. Perhaps you can also add to your supplement, to your testimony, some of the things, some of your plans for this money if Congress appropriates the money.

Dr. AGRAWAL. I will do that.

Ms. DEGETTE. OK. Thanks. Mr. Cantrell, let us see, what would you be able to do with the funding if we adequately funded your agency?

Mr. CANTRELL. Well, first we would hire more investigators, auditors, evaluators, attorneys to support the work that we are doing and actually have more boots on the grounds performing this type of oversight work. We also need investments in technology. As we deploy electronic health record systems throughout the country and that becomes a greater adoption of EHR, that creates digital evidence that we have to collect, store, maintain and sort through. So we need investments in technology to maintain, to kind of stay above water here in this area that continues to evolve.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. MURPHY. Thank you. Now I recognize Mr. Burgess, or Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. So again, I appreciate everyone being here this morning. If I understood your testimony correct, we are doing a great job. If you just give us a little bit more money, we will do a better job, and yet the problem continues. Year after year after year we are here having these same hearings.

Let me just ask—I have got questions that I must ask, but at the same time, I feel obligated to make the statement that, yes, I supported the sequester. It was a policy that I supported, but it was the President who signed it into law. Now, we all knew after the President signed it into law that it was going to affect the Department of Health and Human Services significantly at a time when the President's healthcare law was being implemented. So I had asked repeatedly for someone, the Secretary of HHS, to come to this committee and talk about how you were going to deal with an 8- to 10-percent reduction in across-the-board funding, how were you going to prioritize. I would think, Mr. Cantrell, you would prioritize your department. I don't know why you would prioritize money going to build an exchange that you then had to reinvest when they didn't build the exchange the right way. But I am not the head of HHS, so I don't make those decisions. So please forgive me if I am a little bit circumspect about people coming in here and saying more money for my agency, more money for my agency, when my God, you have wasted so much money in that agency in the last 4 years that it is just absolutely astounding.

Now, let us get to the reason why we are here. Mr. Cantrell, do you have recommendations, your office, the Office of Inspector General, have recommendations and have you made recommendations to the Centers for Medicare and Medicaid Services relating to improvements in the screening of providers that have not been adopted?

Ms. JARMON. I can answer that question. We have several recommendations. In fact, we posted in March 2014 a compendium of priority recommendations that are unimplemented, and that has over 100 recommendations to CMS, many related to Medicare and Medicaid payment and process issues and some related to quality of care. So we do have several recommendations that we have been working with CMS, and they have been unimplemented but——

Mr. BURGESS. Let me just ask——

Ms. JARMON [continuing]. We are still working with them.

Mr. BURGESS [continuing]. The question, Dr. Agrawal or Mr. Cantrell. What is the status of the implementations of those recommendations from the Office of Inspector General?

Dr. AGRAWAL. You know, we have appreciated the recommendations that are provided to us, both by the OIG as well as GAO. We work diligently to implement those recommendations based on our ability to do so, and budgetary and other resource constraints.

Since January 2013, we have completed or closed out over 60 recommendations provided to us by GAO and OIG. We continue to work through the remaining recommendations in order of priority based on their potential impact on our program. But we do appreciate those recommendations.

Mr. BURGESS. Will you provide to the committee a list of those recommendations that have been made which have not yet been implemented? Are you able to do that?

Dr. AGRAWAL. I can do that.

Mr. BURGESS. And the committee would appreciate that information.

There was an article in Bloomberg not too terribly long ago talking about doctors who have lost their licenses and continued to get paid by Medicare. I mean, I always lived in fear—as a practicing physician, I always lived in fear of getting a bad mark at the National Practitioner Data Bank. I would assume that all of these doctors have recorded activity in the National Practitioner Data Banks. Dr. Agrawal, do you query the National Practitioner Data Bank when you authorize or when you permit someone to bill the Medicare system?

Dr. AGRAWAL. Yes. And I share your feelings about my medical license as well, Dr. Burgess. It is something that I guard very carefully and want to make sure is untarnished.

We access a lot of different data sources including the NPDB and over 200 other data sources to check things like licensure. As I said in my opening remarks, we revoked over 800 providers just since the beginning of this year for licensure issues. This was an area of vulnerability for us, even a couple of years ago, that we have really worked hard to close by getting access to all the right data at the state level so that we can do automated checks on licenses literally every week and revoke any providers that don't have appropriate licensure.

Mr. BURGESS. You know, a lot of the substance of this hearing came about because of the local article in the newspaper back home where you had a doctor, a CEO of a hospital chain, who had received $17 million from the stimulus to improve medical records in his system. And then it was found that the medical records were boxed up and sitting in the basement being eaten by rodents. So

I guess you would classify that as meaningless use of health information technology. But yet, at the same time, with this bad and egregious an offense, he continues to get paid by CMS. Is this just a one-off or are there other such stories out there in the country?

Dr. AGRAWAL. I think it is a notable case. It is one that I know well personally. I can tell you that we have a lot of checks in place to ensure that that kind of thing does not happen both before payments are made and after.

Mr. BURGESS. But it did happen.

Dr. AGRAWAL. I agree that it did. I think in part this person was providing misleading information to the agency, and we were also made aware about law enforcement concerns well into their process. And I think OIG would agree here that early collaboration between our agencies is very helpful. That allows us to take the actions that we can take very quickly, and we can work with law enforcement to facilitate their actions as well.

Mr. BURGESS. Then do it.

Mr. MURPHY. Thank you.

Mr. BURGESS. Early collaboration is the key. I yield back, Mr. Chairman.

Mr. MURPHY. Just a quick question. When you are getting that clarifying data for the committee with regard to recommendations you have made that have not been implemented, if they have not been implemented, could you let us, with each one, explain some reason of why that is, if it is some federal action, if there is any state action, if states are not sending you data. That is extremely important. We want to help you, but we need to have that thorough report.

I now recognize the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman, and ranking member. Dr. Agrawal, can you tell me more about how the Affordable Care Act helps CMS in fighting Medicare fraud? Specifically, can you expand a little on CMS's provider enrollment and screening process?

Dr. AGRAWAL. Absolutely, and thank you for the question. The Affordable Care Act has had significant impact on our ability to safeguard the program and particularly in the area of provider enrollment and screening. The ACA really required us to, for the first time, categorize providers based on the risk of fraud and subject higher risk providers to greater levels of scrutiny. That includes automated checks, site visits, fingerprinting. All of that was made possible by the Affordable Care Act.

In addition, our moratorium authority, our requirement to revalidate all providers on a cyclic basis, again, comes out of the ACA.

Mr. GREEN. OK. I appreciate it because some of the savings from the ACA was actually giving CMS the tools to go after the fraud. We would prefer not to read it on the front page of the papers before we can get to you.

The health reform bill includes the authority for CMS enact moratorium on enrolling new providers. Has CMS used this new tool yet?

Dr. AGRAWAL. We have. So we implemented the first moratoria last summer in July. We have moratoria in two different provider categories, ambulance services, and home health services in seven

different metropolitan areas and are closely monitoring the impact of that moratorium.

I should also say while the moratorium is in place, we have really stepped up our activities to make sure that we are taking action on the providers that are already in the moratoria area.

Mr. GREEN. OK. Good. Because I represent the Houston area, and it seems like we are ground zero for some of the fraud, and I appreciate that. How does the moratorium help fight the fraud?

Dr. AGRAWAL. Well, what the moratoria really allows us to do is essentially close the door for enrollment, in this case, for new ambulance services as in Houston or home health agencies in other parts of the country. That gives us an opportunity to clean up the providers or suppliers that are already there and work very closely with law enforcement. We actually work very closely with them in identifying these areas for the moratoria and then in the stepped-up activities to make sure that we are cleaning up those areas before eliminating the moratoria.

Mr. GREEN. OK. The Affordable Care Act required Medicare providers to report and return overpayments once they are identified. Failing to do so would constitute a federal crime under the False Claims Act. Was this requirement necessary and have you seen evidence of providers complying with this requirement and is it being enforced?

Dr. AGRAWAL. I am sorry, Mr. Congressman. I missed the beginning part of your question.

Mr. GREEN. The Affordable Care Act required Medicare providers to report and return overpayments once they are identified, and failing to return those payments would constitute a federal crime under the False Claims Act. I was wondering if this is being enforced and how it is working.

Dr. AGRAWAL. Yes, we published a proposed rule on this, and we are looking to finalize that. We do see providers actually taking just the statutory authority seriously itself and actually returning overpayments voluntarily. We have also promulgated another proposed rule that would actually have overpayments follow providers if they try to close down one location and open up another one. They will have to pay the overpayment before they can get into the program again.

Mr. GREEN. OK. Ms. King, do you have a view on how CMS is doing at implementing the broad range of new Affordable Care Act anti-fraud positions? And after you, I would like to give Dr. Agrawal a chance to respond.

Ms. KING. Yes, we view the new provisions in the Affordable Care Act as a positive step because we are in favor of keeping people out of the program who shouldn't be in the program, and right now our investigative team has work under way to determine whether people are being kept out of the program as they should be and whether people who have committed bad acts and should be thrown out of the program are being thrown out. And we should be able to report on that by the end of the year.

Mr. GREEN. OK. Thank you. Dr. Agrawal, do you have a comment on that, how CMS is doing with the GAO?

Dr. AGRAWAL. Sure. And again, I appreciate Ms. King's comments and agree that their recommendations are very important.

We have done a lot based on their recommendations to strengthen our program in Part D, in basic provider enrollment and screening. There are other recommendations that we continue to work through, but they are very helpful to us.

Mr. GREEN. OK. Thank you, Mr. Chairman. I yield back.

Mr. MURPHY. Thank you. Now I recognize Ms. Blackburn for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman. Dr. Agrawal, I want to come to you. You mentioned in your testimony that since 2011, 20,000 providers and suppliers had their participation in Medicare revoked and some from felony convictions and some from administrative actions. And also, you mentioned that CMS has issued a proposed rule that would clarify the list of felony convictions that may result in a denial of participation. And yet, I have heard from constituents that some of these bad actors that are out there continue to do business because they change their names and they start a new business. But it is the same bad group of people. And we have seen this time and again, and I know the chairman, a couple of years ago, had a piece of legislation that went through judiciary, didn't get very far at the time. We need to bring it back. It would say if you have ever been convicted, you can in no way participate and benefit.

GAO has recommended that CMS could potentially thwart this type of behavior by strengthening enrollment procedures as is currently authorized, and CMS could require additional disclosure information on the front end. And yet, according to GAO, it hasn't been done. My question to you is this. After 20 years after being on a fraud high-risk list, when can the taxpayers expect to see results from some common-sense activity in this arena?

Dr. AGRAWAL. Well, I think we clearly are seeing results, and I think you saw that in the testimony that I provided to the committee this morning that there are clear results of our activities. Now, I, too, am frustrated by the kind of case that you are identifying. If there are cases like that specific ones that we can work on with your office, I would be happy to do that.

Let me just say that we are working toward strengthening disclosure requirements. We actually have a proposed rule that would require far more disclosure to resolve issues just like that so that we can actually prevent people from entering the program that are just changing names and switching from company to company. I think that kind of approach is indeed very frustrating, and we are working to expand our authorities to get greater clarity.

Mrs. BLACKBURN. Well, you are not giving me the granular level that I am seeking. Tell me specifically what you are going to do because when I talk to my constituents, they say we want to know specifically what is going to be done about this. It is our money, and you are wasting it.

Dr. AGRAWAL. Well, beyond the overall approach that I have described, there are two things that I think will affect the situation. One is we are expanding our ability to actually revoke or deny enrollment for a broader list of felony convictions than we currently are authorized to do, and second, we are requiring greater transparency at the time of attempted enrollment so that if there are overpayments from other enrollments that that provider had, we

can actually deny enrollment until those overpayments are recovered. Those are two very specific things that I think will go directly at the cases that you are talking about.

Mrs. BLACKBURN. But why did we let them in the program in the first place?

Dr. AGRAWAL. Well, again, historically, I think Medicare has had a more open enrollment process than it has had since the passage of the Affordable Care Act. So we are working very diligently every day to clean up those records and hence, the numbers that you have seen of over 300,000 deactivations and over 20,000 revocations ——

Mrs. BLACKBURN. OK. Does CMS give bonuses?

Dr. AGRAWAL. Pardon me?

Mrs. BLACKBURN. Does CMS give performance bonuses to employees?

Dr. AGRAWAL. I am not sure. I don't really manage our HR function. I don't know what kind of bonuses——

Mrs. BLACKBURN. Do you get a performance bonus?

Dr. AGRAWAL [continuing]. That we do. I joined the agency in this role 3 ½ months ago.

Mrs. BLACKBURN. OK.

Dr. AGRAWAL. I haven't qualified for bonuses.

Mrs. BLACKBURN. Mr. Cantrell, did you get a performance bonus?

Mr. CANTRELL. We do pay performance bonuses in OIG based on our ranking of record.

Mrs. BLACKBURN. OK. Ms. Jarmon, HHS, do they do performance bonuses?

Ms. JARMON. I am in the same office with Mr. Cantrell. There are performance bonuses based on performance.

Mrs. BLACKBURN. OK. All right. Let me come back, Mr. Cantrell and then also—let me talk to you about this issue. I have got a prop back here.

[Chart shown.]

Mrs. BLACKBURN. Identity theft and privacy is a huge issue, and this is something we have tried repeatedly to get cleaned up. This is a copy of a Medicare card. Now, what we have that is a problem with identity theft, you have got the program, the health insurance program it is in, Medicare. You have got the name. And this Medicare claim number is the Social Security number. When are you going to delink these and make certain that a Social Security and a name do not appear on this card? When are you going to change that?

Dr. AGRAWAL. I think you are probably asking me, not Mr. Cantrell. So we have——

Mrs. BLACKBURN. I am sorry. I thought I called for you and then I would like to know from Ms. King, has GAO recommended doing this?

Ms. KING. We have.

Mrs. BLACKBURN. OK. Back to you, Doctor.

Dr. AGRAWAL. So this is an area——

Mrs. BLACKBURN. Why not?

Dr. AGRAWAL [continuing]. We have looked at. We have appreciated the recommendations. We are not, as an agency, opposed to

the idea. It is, however, a challenging idea that requires a lot of sort of rigor to implement——

Mrs. BLACKBURN. Do something. Take an action. Be brave.

Dr. AGRAWAL. I think we need to be adequately resourced——

Mrs. BLACKBURN. I yield back.

Dr. AGRAWAL [continuing]. By the Congress to be able to do that. But yes, we appreciate the ability.

Mr. MURPHY. Dr. Agrawal, do you have the authority to make that decision to eliminate the Social Security number from the cards?

Dr. AGRAWAL. I think we as an agency could do that. Again, however, as we have discussed this with the GAO, making this change would require changes to over 70 systems that CMS has. It would also require changes to state Medicaid agency systems, private insurers that deal with us in Part C and D as well as even potentially on the provider side. So there is quite a bit of burden across the healthcare community to make this change. Again, we are not opposed to it. I think as an agency we just need to be adequately resourced to be able to take on that challenge.

Mr. MURPHY. Just don't hire the same company that did the Obamacare rollout. You can do better. Ms. Schakowsky first.

Ms. SCHAKOWSKY. I would like to talk a little bit about fraud and the Medicare Part D program. Dr. Agrawal, CNS released a Medicare Part D proposed rule in January of 2005. What steps did that rule take to reduce fraud in Medicare Part D?

Dr. AGRAWAL. So just to clarify, this is the rule that we finalized now 3 weeks ago, or roughly 3 weeks ago, is that correct?

Ms. SCHAKOWSKY. Yes.

Dr. AGRAWAL. Yes. I think that rule is going to have really important impact for us in Part D. One thing is it extends our controls and safeguards in Parts A and B to Part D. It will actually require an enrollment of providers in the Medicare program to—even if all they do is prescribe in the Part D program. So we will have much more transparency into who those providers are, and I think importantly, we can keep revoked and excluded providers out of the Part D program so they can no longer prescribe.

A second big impact is that it will allow us for the first time to go after abusive prescribing. So this will be not just those prescribers that have actually committed fraud but will allow us to go upstream of the problem and actually be much more preventive to make sure that prescribers that are endangering the safety and health of our beneficiaries, for example, can be taken action against and we can actually kick them out of the program.

Ms. SCHAKOWSKY. So it is a financial issue, but also a health issue for a patient?

Dr. AGRAWAL. Absolutely.

Ms. SCHAKOWSKY. OK. So I appreciate these steps. Fraud in Part D appears to be a problem that is increasing, and it is important that CMS act quickly to nip this fraud in the bud.

Mr. Chairman, fraud is not the only problem with Medicare Part D. Waste and abuse is also a problem. In particular, taxpayers and beneficiaries are forced to pay too much for prescription drugs because Medicare Part D plans are not able to negotiate for lower prices. The poster child for high Medicare Part D prices will soon

be Sovaldi, which Mr. Waxman was talking about, the Hepatitis C drug manufactured by Gilead. The company charges $84,000 for a course of treatment. A recent analysis by researchers from Georgetown University and the Kaiser Family Foundation found that Medicare Part D coverage for Sovaldi alone would increase Medicare drug spending by $6.5 billion, or 8 percent, in 2015 which is an astounding amount of money for one drug. While Gilead provides substantial discounts on this same drug in other countries and for the VA and the Medicaid program, these discounts are not available to Medicare Part D plans. According to the studies' authors, "It is likely to be hard for Part D plans to have an impact on the price in the case of Sovaldi. Part D sponsors have little negotiating power."

Mr. Chairman, Sovaldi is not unique. Part D plans are not able to obtain significant discounts on many expensive drugs. So Mr. Cantrell, the Inspector General has conducted analyses of Part D drug prices and compared prices charged for the same drugs on Medicaid. Can you tell us what those investigations have found?

Mr. CANTRELL. I can tell you that Part D drug prices are higher. We are paying more in Medicare than we are in Medicaid, and our work has come out of the Office of Evaluation and Inspections and somewhat from the Office of Audit Services. So I will pass on to Ms. Jarmon.

Ms. SCHAKOWSKY. OK.

Ms. JARMON. One of the things we have looked at are rebates—the Part D drug prices were higher than Medicaid prices because Medicaid received higher rebates. Average rebates for Medicaid drugs were 45 percent of the cost while average rebates from Part D drugs were only 19 percent of cost. And in the Compendium of Unimplemented Recommendations, we actually have several recommendations related to payment policies, looking at lab costs, and the differences between Medicare and Medicaid prices for these same services.

Ms. SCHAKOWSKY. And how much would the—so you are saying that there is an administration proposal that would end the waste and require higher rebates for Part D drugs, is that right?

Ms. JARMON. I am not sure if there is a proposal.

Ms. SCHAKOWSKY. Dr. Agrawal?

Dr. AGRAWAL. There is. There is an item in the President's budget that would put Medicare payments on par with the Medicaid rebates.

Ms. SCHAKOWSKY. And how much would that proposal save taxpayers?

Dr. AGRAWAL. I would have to look back at the O Act estimation. I can get back to you about that.

Ms. SCHAKOWSKY. OK. The number I have heard, and you can confirm it, is about $150 billion would be saved by that one change.

Dr. AGRAWAL. Right.

Ms. SCHAKOWSKY. And I would certainly support that change. Thank you, and I yield back.

Mr. MURPHY. Thank you. Now I recognize Mr. Olson for 5 minutes.

Mr. OLSON. I thank the chair for having this hearing that is required by our rules. Welcome to all the witnesses. Before I get to

my questions, I want to tell you about what Medicare fraud looks like back home in Texas 22, in Houston in particular. These are some stories that have been in local papers. January 24, 2014, "Houston medical device supplier charged with $3.4 million in Medicare fraud." February 2, 2 weeks later, Houston psychiatrist indicted for $158 million in Medicare fraud. February 29, Houston physician arrested in healthcare fraud conspiracy. In that case, CMS missed the fact that one person had been tested 1,000 times and billed those tests over a 3-year period. April 3 of 2014: "Houston businesswoman convicted of $1.5 million in Medicare fraud." April 24, 3 weeks later: "$70 million alleged healthcare scam busted in Texas." And finally, June 4 of 2014: "Houston physician and four others indicted for $2.9 million in healthcare fraud in state and federal case." That is 6 months and $200 million in fraud in Houston. And that is what we have known. That is what has been charged, what has been put in the press. We know that it is much, much worse in Houston and all across America.

One area of abuse is billing Medicare for ambulance services that aren't given or provided or needed. As was mentioned by some of our witnesses, Houston is one of seven cities in America that have a moratorium on new ambulance services under Medicare. And I believe, Mr. Cantrell, in your testimony you said that because of the moratorium, Houston's costs have gone down 50 percent since 2010. Is that correct?

Mr. CANTRELL. I am not linking it directly to the moratorium, sir, but based on our collective efforts, yes, our enforcement efforts and administrative efforts.

Mr. OLSON. You anticipate my question. So it is not due to moratorium. It may be due to putting people in jail as opposed to some sort of combination thereof?

Mr. CANTRELL. Absolutely. We think putting people in jail who commit these crimes is paramount to success in this area.

Mr. OLSON. Can you get us that data, separate the moratorium from actually putting people in jail? Is that possible?

Mr. CANTRELL. We haven't studied that, the impact of the moratoria. I don't know if Dr. Agrawal——

Mr. OLSON. Dr. Agrawal, any possibility of having that information?

Dr. AGRAWAL. Well, we are monitoring the certain measures like utilization and cost in the moratoria area. I think statistically it is very hard to desegregate all the work that we are doing from the moratorium alone. In fact, we bring a package of activities between us and the Office of Inspector General that allow us to attack these problems head on. The moratorium is one component. We also have, as you saw the report, the fraud prevention system enrollment requirements. So I think all of those things together clearly have impact. It is very hard to desegregate and say that this is the impact of one of those things.

Mr. OLSON. Do you plan to expand the moratorium?

Dr. AGRAWAL. Pardon me?

Mr. OLSON. Do you—expand the moratorium with the seven cities, make it go longer?

Dr. AGRAWAL. Well, what we are doing currently, since this is a new authority and the first time that CMS has really implemented

it, is that we are studying it to see what impact it does have, making sure that it plays a useful role in our toolbox and that it allows us to take action against providers that are already in those areas.

So until we know the answers to those questions I think, given that it has a real impact on even potentially legitimate providers, we want to be careful about expanding that authority until we really have a sense of what it does for us.

Mr. OLSON. Any idea of when that timeframe will come out and when you can tell us this is working, we will expand it in a year, 2 years, 3 years, 4 years?

Dr. AGRAWAL. Well, we are required by the statute to publish a federal register notice every 6 months in order to continue the moratorium or eliminate it or implement new ones. So we will be looking forward to publishing a notice within the next month with that decision.

Mr. OLSON. So if you expand it to the seven cities currently involved in the moratorium that you will take more cities, 12, 14, 15, 20, 25 to see if it is working? It seems to be working. Costs have gone down 50 percent since 2010. Let us go forward.

Dr. AGRAWAL. Yes, again, I think we are very open to using this authority more. I think we just want to be able to know what its impact is and make sure that we are not negatively impacting legitimate providers or beneficiary access to care. I think that is really paramount for us as an agency.

Mr. OLSON. Thank you, and I have 47 seconds left. Mr. Burgess, would you like my time or——

Mr. BURGESS. Yes, let me just ask a question on the predictive modeling issue. Prior to the passage of the Affordable Care Act, was there any prohibition on using predictive modeling?

Dr. AGRAWAL. Well, sir, in fact the predictive modeling became a requirement from the Small Business Jobs Act which preceded the ACA. There was no prohibition. I think what the Small Business Jobs act really gave us was the necessary funding to be able to implement this kind of advanced technology.

Mr. BURGESS. But predictive modeling has long been known, particularly among the credit card agencies. I mean, I don't know how many years they have used this, but it has been some time. It is a reliable way to cut down on fraud. One of the things I have never understood is why CMS has been so slow to embrace it. I will yield back.

Mr. MURPHY. Thank you. I now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair, and welcome to our panelists. Yesterday the Second Annual Fraud Prevention System Report to Congress was released which detailed some of the accomplishments of CMS in the fiscal year 2013 to identify bad actors and again protect Medicare. If we could just visit those report findings for a moment, for starters, Dr. Agrawal, can you just give us a basic description of what the fraud prevention system is and just how it works?

Dr. AGRAWAL. Sure. So the fraud prevention system is an advanced piece of technology. It allows us to perform predictive analytics and other kinds of analytics on claims in Medicare as they are streaming through the system in real time. So the Medicare

program sees about 4.5 million claims per day. This allows us to more quickly and specifically identify those claims that need to be evaluated by our investigators, and further develop to see if they represent aberrancies or even fraud.

Mr. TONKO. And beyond that, are there other things that enable your office to do that that was not previously available? Are there new opportunities here with that system?

Dr. AGRAWAL. Yes. I think the system itself is a great piece of technology that allows us to, again it would be impossible for a human being to lay eyes on all 4.5 million claims per day. The fact that we have an automated system to pull out those claims and those providers that are really problematic is an amazing step forward for us.

In addition to that, it allows us to do certain things as well, like simply deny claims that don't meet payment requirements, which is an ability that the agency had before but the FPS allows us to do it more flexibly and quickly.

Mr. TONKO. And what kind of investment has been made by CMS in the prevention system?

Dr. AGRAWAL. The Small Business Jobs Act came with about $100 million of funding for the fraud prevention system that we have been utilizing in its implementation. You know, as I think we have pointed out earlier, we implemented the system on a very rapid timeframe and actually exceeded the expectations of the statute by going to a national view as opposed to a regional view which the statute required initially. We have also shown good progress in the implementation, going from a 3-to-1 ROI to now this year a 5-to-1 ROI that I would point out has actually been certified by the Office of Inspector General.

Mr. TONKO. So any expanded opportunities there in terms of fiscal impact? You see it improving even beyond that?

Dr. AGRAWAL. Yes. We have undertaken various measures to increase the value and return of the FPS. We are, for example, applying it against a wider spectrum of program integrity issues, actually using it to identify providers for medical review, as one example, being able to implement those automated edits as another example. We do look forward to the value of this program increasing.

Mr. TONKO. OK. Thank you. And Mr. Cantrell, are you familiar with the FPS system and with the results that were released yesterday?

Mr. CANTRELL. I think Ms. Jarmon is the person to answer that question, if you don't mind.

Mr. TONKO. Ms. Jarmon?

Ms. JARMON. Yes. It is not a part of the Office of Investigations—the OIG office of Audit Services actually did that work looking at the fraud prevention system the second year. The first year we weren't able to certify the information because of inconsistencies, and the second year we were able to certify both the unadjusted number, the number before adjustments, and the adjusted number to reflect what actually gets returned to the Medicare trust fund. We were able to certify both numbers in the report that went out late yesterday, the larger number being $210 million of unadjusted projected actual and projected savings, and the adjusted number of $54.2 million is a 1.34-to-1 return on investment.

Mr. TONKO. And basically what is the significance of the certification?

Ms. JARMON. The significance is that the auditors actually looked at supporting documentation. They actually did work similar to financial audit work to determine the reasonableness of the numbers. So the numbers actually started out as the larger number, and we worked closely with CMS on any concerns we had if we couldn't directly associate these savings to the fraud prevention system so we really got comfortable with the unadjusted number. Like I said, it started out as a larger number. So it was the audit work that was done to make us feel comfortable that we could certify the numbers this year.

Mr. TONKO. Thank you. And earlier you were quizzed as a panel about the legislative recommendations for further improvements in anti-fraud. Could any of you highlight which of those recommendations would be your top priority?

Mr. CANTRELL. From a law enforcement perspective, our ability to have asset seizure authority is important to OIG, but also removing the Social Security number from the Medicare beneficiary card is important from an identity theft perspective, preventing identity theft.

Mr. TONKO. Do you all share that same priority?

Ms. KING. Yes. I think from our perspective the removal of the Social Security number from the cards is a very high priority.

Mr. TONKO. OK, and Dr. Agrawal?

Dr. AGRAWAL. Well, being from the agency that I am, I don't get to make the recommendations. I get to implement them. So, again, we look at all of them. There are others that I think have very high priority because of their impact on our enrollment and screening work. The SSN issue is one that we have looked at specifically. Again, we are open to that recommendation, but need to be resourced appropriately to meet its requirements.

Mr. TONKO. Thank you very much. I yield back.

Mr. MURPHY. Thank you, Mr. Tonko. I would like to get some clarification on something the gentleman asked you. On page II of the Executive Summary of this document you released last night, the Report to Congress, Fraud Prevention, you indeed say in this little blue box, "The results are a 5-to-1 return on investment almost double the value of the FPS in the first implementation year." But then when we get into the meat of the text on—it also says in here, what we found, it says Medicare fee for service program and return on investment on—it is only $1.34 for every dollar spent on the FPS. Can you justify for us what that distinction is?

Dr. AGRAWAL. Sure. So number one, let me just say, either number, both numbers, demonstrates that the fraud prevention system has had a positive ROI. The two numbers are something that Ms. Jarmon alluded to. There is an unadjusted savings number and then an adjusted savings number. We believe in the agency that the unadjusted savings number most directly measures the impact of the fraud prevention system.

Mr. MURPHY. In which one of those, the $5 or the $1.34?

Dr. AGRAWAL. The 5-to-1 ROI. And the reason for that is because the FPS is a piece of technology, again, as I have pointed out earlier that points to those claims and those providers that need fur-

ther investigation. What the adjusted number gives you is the downstream impact of all of a series of work. So not only the outcomes of the investigation, the outcomes of any administrative processes, any recovery processes and the work of law enforcement referrals.

So it reflects dollars returned to the trust fund, but the FPS was not designed to impact the entire downstream process.

Mr. MURPHY. Ms. Jarmon and Mr. Cantrell, then he is saying your numbers aren't accurate. Is it $1.34 or is it 5-to-1?

Ms. JARMON. Well, both numbers show again the positive effect of the fraud prevention system.

Mr. MURPHY. Sure.

Ms. JARMON. But in Office of Inspector General, we feel more comfortable with the adjusted number which shows the return on invest of 1.34-to-1 because that reflects the actual amount that is expected to be returned to the Medicare trust fund. The larger number is the number before adjustments. In some cases assets were not there to be collected. So the larger number—while it was identified by the Medicare contractors, what actually is going to come in is the adjusted number with the expected return of investment of 1.34-to-1.

Mr. MURPHY. Thank you. I appreciate that. I now recognize Mr. Johnson of Ohio for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman, and I thank the panel for being with us today. You know, one of the ways that has been suggested to fight fraud is increase disclosure of prior actions against providers and suppliers that were enrolling or revalidating their Medicare enrollment. So Dr. Agrawal, has CMS issued a rule on increasing disclosure of prior actions?

Dr. AGRAWAL. Yes, we have actually put out a proposed rule that will allow for more disclosure. But one thing I would point out is, again, disclosure is one aspect of a program integrity approach. If these are really criminals, then they probably won't have much of a problem lying on an application. So we have a lot of other resources at our disposal that include data checks that go beyond anything that somebody puts on an application. And those I think data checks have had significant impact on our ability to keep people out of the program or remove them if necessary.

Mr. JOHNSON. OK. Mr. Cantrell, Ms. Jarmon, would, in your opinion, would such disclosure help fight fraud, for instance? Would contractors that CMS currently works with, say Medicare Advantage and drug plan sponsors, be better able to identify fraudulent providers up front if they had access to such information?

Mr. CANTRELL. Well, I think for one thing, if they lied on the application, it would be a means for us to charge them with that actual crime. So we like that attestation by the provider or whoever is attesting to the facts on the application so that we, or in this case, someone might withhold some information, to use against them as evidence if you will of intent to commit fraud. So I think it would help our efforts on the prosecution and enforcement side.

Mr. JOHNSON. OK. Ms. Jarmon, any comment?

Ms. JARMON. Yes, and it is in line with what we have also been recommending that the Part C and Part D contractors report fraud

also so that they can use that information to try to make sure the bad actors are not in the program.

Mr. JOHNSON. OK. Ms. King, are Medicare contractors able to share such information with each other? For instance, if a patient or provider is suspected of fraud and they change plans during open enrollment, would a plan a beneficiary is leaving be able to communicate with a plan they are joining about the suspected fraud?

Ms. KING. I am not sure of the answer on that. Let me get back to you.

Mr. JOHNSON. Can you take that for the record and get back——

Ms. KING. I don't believe they can, but I am not positive.

Mr. JOHNSON. OK. All right. Well, certainly it would be good if they could, right? OK. Also for Ms. King, Medicare administrative contractors known as MACs, MACs were created about a decade ago. Today they serve as the primary bill payers for Medicare claims. Given that the bulk of Medicare reimbursements are processed by MACs, the bulk of improper payments are also made by MACs. I know GAO is currently wrapping up work examining the work of the MACs. Do you have any early observations on your work that you can share with our committee?

Ms. KING. Not from the work that is ongoing, but we did release some work recently that looked at a lot of their requirements. There are different types of contractors that do post-payment review for fee-for-service claims, and we found a lot of variety among the requirements that they are subject to which is a source of confusion for providers. And we recommended that the CMS take steps to align those requirements where it wouldn't hurt program integrity efforts.

Mr. JOHNSON. OK.

Ms. KING. So streamlining—not streamlining but making the requirements more consistent across contractors—we think would be helpful.

Mr. JOHNSON. OK. And then a follow-up, Ms. King. GAO has conducted work looking at CMS's management of all program integrity contractors. GAO made several interesting findings including the fact that CMS did not standardize its requirements for all contractors. One of the consistent findings from GAO's work over the years is that CMS will often sign a contract for a program integrity function but either fail to measure the right functionality and activities from the contractor or failed to assess progress as the contractor conducts the work.

So in what ways do you think the current contracting mechanism that CMS uses, which is subject to the federal acquisition rules or the FAR, might hinder CMS's flexibility to manage the program well?

Ms. KING. Are you referring to the MAC's or the program integrity contractors', if I might ask a clarifying question?

Mr. JOHNSON. I think we are talking about management of all program integrity contractors.

Ms. KING. OK. We did some work recently that evaluated the program integrity contractors that are called ZPICs, and we did find that they had a positive return on their investment. And they are FAR contracts subject to the FAR and they are cost plus award

fee contracts. We made some recommendations to CMS that they could further link the program integrity contracts with the agency's higher goals in the GPRA Act so that the goals from the top of the agency flow down through the program integrity contractors.

Mr. JOHNSON. OK. So do you think that the current contracting mechanism that CMS uses would hinder their flexibility to manage the program well?

Ms. KING. I don't have reason to believe that it does.

Mr. JOHNSON. I yield back, Mr. Chairman.

Mr. MURPHY. Thank you. I now recognize Mr. Long for 5 minutes.

Mr. LONG. Thank you, Mr. Chairman, and thank you all for being here today. Ms. King, I want to direct my questioning toward you, and in my questioning I would like to focus on the issue of post-payment audits within the Medicare program and the effect they are having on hospitals and small businesses across the State of Missouri.

In the Dallas airport last Friday I ran into a fellow that happened to be one of my constituents. We both happen to be flying back to Springfield, and he owns a prosthetics and orthotics company. If you go to Google and look that up, O&P, it is the evaluation, fabrication, and custom fitting of artificial limbs and orthopedic braces. I am sure you know that—but custom fitting. He sat and told me that Medicare is sitting on a quarter million dollars or better in these RAC audits. And so as I go through this little line of questioning that I have here, I want you to keep in mind that fellow. It is him and his wife and his son. They own a little O&P business in my district, and think about a small businessman that is sitting around waiting for a quarter million dollars and when he might see that money.

But as you know, Medicare currently contracts with private vendors referred to as recovery audit contractors, RACs, to perform these payment audits. These contractors are paid on a contingency fee basis receiving a share of the improper payments they identify, and they are not penalized if the alleged improper payments are overturned on appeal. So they are going to hold this money and try and prove—because they are going to benefit if they are going to make money by proving that these were paid when they shouldn't have been paid. But if they are wrong and they hold this guy's money forever and put him out of business, if it is overturned on appeal, there is no penalty for those companies. As a result, the demands with the contractor for medical and billing records have nearly doubled since 2012. Ultimately this has resulted in administrative quagmire where the Office of Medicare Hearings and Appeals has suspended the ability for providers to appeal their decisions due to the backlog of almost 357,000 cases they are backlogged. So they have suspended it.

I recognize that the post-payment audits are an appropriate tool for HHS to employ and have also successfully recovered millions from genuine bad actors in the system. But there are a lot of small business people just like my constituent that are out there waiting for this money. Now it has been suspended. The people that are doing the audits are getting paid for what they find, and even if it is overturned on appeal there is no penalty for those people.

So one question I have is do you believe that the current structure of the system is designed in such a way that it incentivizes quantity over quality of these audits?

Ms. KING. Let me answer your question in several parts. You are correct that the RACs are paid on a contingency fee basis, and they are paid differently from all of the other post-payment review auditors who are paid on a cost basis. And initially, the RACs were not penalized if payments were overturned on appeal, but now they are. So if they lose on appeal, they have to——

Mr. LONG. OK. I——

Ms. KING. There is a penalty there.

Mr. LONG. I had incorrect information on that, ma'am.

Ms. KING. It was initially correct. The volume of audits done by the RACs has increased substantially over the last several years, and they do by far——

Mr. LONG. Have they doubled since 2012?

Ms. KING. Oh, more than that. Well, not since 2012 but probably since 2010 or 2011. And for example——

Mr. LONG. My information says 2012, but OK.

Ms. KING. They have gone up a lot and your——

Mr. LONG. Are there 357,000?

Ms. KING. Yes, they are out of the——

Mr. LONG. Backlogged?

Ms. KING. Of the $2.3 million of—2.3 million post-pay audits in 2012, about 2.1——

Mr. LONG. Those are audits, not dollars, right?

Ms. KING. Audits, yes.

Mr. LONG. OK.

Ms. KING. 2.1 million of them were done by the RACs. You are also correct that there is a huge backlog in appeals, and we have——

Mr. LONG. What do you do for a small business guy like mine? He and his wife and his son are trying to make a living in a custom-fit part that is not returnable. Nobody else can use that. If they say, oh, you shouldn't have got that part, we should not reimburse you for that part, what do you do in that situation? I mean, what can we do?

Ms. KING. Well, I think there are a few things. One is that I would be curious to know what the reason is for the payment being declared improper. If it is a documentation error——

Mr. LONG. But the company that is declaring it is going to get compensated if they can prove that it is, whether it is or not.

Ms. KING. No. But there——

Mr. LONG. Maybe you can correct me on this, too.

Ms. KING. There——

Mr. LONG. Excuse me, ma'am.

Ms. KING. Oh, I am sorry.

Mr. LONG. It is my understanding that like it is 93 and above, maybe 97—93, 97, somewhere in that range of these 357,000 cases are going to be adjudicated have been fine in the first place, and the small business guy should have been paid his money. Is that correct? Is it over 90-some percent that were——

Ms. KING. I don't know the numbers on that.

Mr. LONG [continuing]. Proper in the first place and they were holding this money?

Ms. KING. I don't know. I don't know the numbers on that but——

Mr. LONG. OK. Well, can you find out for me and see if that is accurate, if it is above 90-some percent that they say, oh, yes, we should have paid you months and months and months ago, maybe after he's out of business?

Ms. KING. Well, I have been asked to look at the appeals process and look at the backlog and determine what some of the underlying reasons are and to figure out whether we have any recommendations for solutions.

Mr. LONG. Has the GAO ever made any recommendations and more efficiently reviewed claims after payments were made?

Ms. KING. We have made some recommendations to improve the consistency of the requirements that the post-payment review audit contractors are subject to, and we have further work under way that is looking at the post-payment review process, and that should be out later this summer.

Mr. LONG. OK.

Mr. MURPHY. Gentleman's time has expired.

Mr. LONG. Thank you. I yield back.

Mr. MURPHY. Now I recognize Ms. Ellmers for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panel. I have a number of questions, so I would really like to get right into my questioning. And I just want to start by saying, just as my colleague, Mr. Long—I also, as we all do, have constituents who are very, very concerned about this issue. They are small business owners. They are medium-sized business owners. They are taking care of our patients. They are taking care of Medicare patients.

Now, I just want to outline for you just how ridiculous this process is in relation to the MAC, both RAC and MAC, absolutely ridiculous.

Oxygen, CPAP, hospital beds. They outline for me over a year's time—we are talking about 2,600 of those filled. Of those, they have 1,228 audits. That is 46 percent. Why would any business have to be audited 46 percent? Dr. Agrawal?

Dr. AGRAWAL. Thank you for the question. I think you highlight a really important and complex topic, so I think what this highlights is—and we try to achieve a balance every day between not being burdensome on providers, making sure that beneficiaries can get access to the services that they need, and yet being fiscal stewards of the trust fund as required by law.

Mrs. ELLMERS. And——

Dr. AGRAWAL. And these are areas—just to complete the thought, if you don't mind. DME supplies, orthotics and prosthetics are areas that the OIG has identified as being very high for improper payment rates.

Mrs. ELLMERS. OK. I am going to stop you right there——

Dr. AGRAWAL. Seventy percent of DME alone.

Mrs. ELLMERS [continuing]. And reclaim my time because the issue here is they are not getting paid. The product has gone out to the patients, to the family that is taking—the caregivers who are

taking care of this patient. This patient has oxygen, this patient has a hospital bed. But they have not been paid. And the timeline, the ridiculous timeline. You know, we are talking about the process of the audit, and then we have the redetermination period. Then we have the reconsideration period, and now the Administrative Law Judge, they are coming in and saying, you know what? We can't even take anymore new appeals. You know, there is going to be a 2-year waiting list just to get a hearing. How can anyone run a business if they are not going to get paid for some of the most basic—I am a nurse. These are basic items that our seniors need and use every day. How can these gentlemen that run this business in my district continue to keep their doors open when they are not getting paid? Can you please just tell me how that can be possibly addressed?

Let me back up also. One of the issues in talking about the fraud—and this is what I see here. There is fraud. We all know that there is fraud and abuse of the system. But you are going after the good guys to make up the dollar difference. You are not addressing the real fraud issues that are there. You are not taking recommendations and applying them. Your own recommendations—let me ask a question, Dr. Agrawal. As far as the audit system, if the provider is found to, you know, have a low denial rate, why are we not rewarding them? Why are we not saying, look, you are in this category, whether you want to score them, grade them. Why are we not rewarding them?

Dr. AGRAWAL. I think that is a great point and idea. In fact, that is something that we got from the provider community and we are actually implementing in the next round of RAC contracts.

Mrs. ELLMERS. And when will that round be?

Dr. AGRAWAL. Well, we have been engaged in that procurement for a while now, but the procurement itself has come under protest. So we would have looked forward to actually having it completed by now. But it is currently in that protest process.

Mrs. ELLMERS. And who is protesting it?

Dr. AGRAWAL. Other contractors.

Mrs. ELLMERS. So these folks, my constituents and every other provider is just left in limbo right now, not getting paid?

Dr. AGRAWAL. Well, I would point out——

Mrs. ELLMERS. You know, being good actors, playing by the rules, doing everything they can. They are not getting paid, and we are waiting because someone is protesting?

Dr. AGRAWAL. Let me just say that these audits are required by law. The contingency fee structure was set up in statute. This is not typically the way that—most of our other contractors are not paid that way, either. They also post-pay audit, so they did in fact get paid. These are—and just to differentiate sort of improper payments from fraud, these are tools that we actually utilize to lower the improper payment rate, which this committee has identified as a priority, I think we can agree. And you know, the areas that the RACs have gone after are areas where there is high cost and high improper payments. The DME supplies I just pointed out——

Mrs. ELLMERS. Well, how is it——

Dr. AGRAWAL [continuing]. Are those areas——

Mrs. ELLMERS. How does the RAC auditor—how do they determine—what is it that makes them, that puts the red flag up that they need to go in and audit? What is it?

Dr. AGRAWAL. I think one of the best early indicators is where the improper payments are based on our CERT audits that are also required by law. So the CERT audits pointed out for example that the improper payment rate in DME is about 70 percent so——

Mrs. ELLMERS. OK. But why—OK. So XYZ provider now has auditors, and what is it that they did that alerted the RAC auditor to come in?

Dr. AGRAWAL. Oftentimes it is the area in which they operate. Again, the areas of high——

Mrs. ELLMERS. What do you mean the area?

Dr. AGRAWAL. So if they are a DME supplier and 70 percent of DME payments are improper, then you are obviously going to go——

Mrs. ELLMERS. So DME provider is just subject to a random audit at any given time?

Dr. AGRAWAL. It is not typically random. It is based on real analytical work to see where improper payments could reside among the specific suppliers. In addition, as I mentioned to you, we are very interested in rewarding those that have low denial rates so that they get audited less frequently and at less volume.

Mrs. ELLMERS. But we don't know when that will happen because we are in a protest.

Dr. AGRAWAL. We want to get the RACs up and running as quickly as anybody else.

Mrs. ELLMERS. OK. Thank you, Mr. Chairman, for indulging me. I am over my time, but I would like to submit for the record and ask unanimous consent, there is a memorandum to OMHA Medicare appellants on the time, the length of time for the Administrative Law Judge hearings on the claims and entitlement appeals.

Mr. MURPHY. Thank you. Any objections?

Ms. DEGETTE. Let me see that document.

Mr. MURPHY. Could you send that document over here for a second. Thank you. While that is being looked over, let me just ask a question here that I think is important, too. When people get caught for Medicare fraud—is that acceptable? That is acceptable for the record.

[The information appears at the conclusion of the hearing.]

Mr. MURPHY. When people get caught for Medicare fraud, are they going to jail? Are you fining them? What kind of examples can they be made of, if I can end with a preposition there? So are there current penalties that are incurred upon folks who are involved with Medicare fraud? Mr. Cantrell?

Mr. CANTRELL. They are going to jail more and more. The DOJ reported in strike force cases over 2013, the average length of sentence was 52 months. And that is a fairly substantial time for this kind of crime, and that is an average from 2013. Over the last several years the average has been since the implementation of the strike force, 47 months. So they are going to jail. There are criminal fines. There are criminal forfeitures that are applied, and that is the work that results in the recoveries that the government has received.

Mr. MURPHY. So can I ask then, of those who are—when you catch someone, the likelihood that they will serve time, they will pay a fine, any idea what those numbers are like?

Mr. CANTRELL. I don't have the percentage, sir.

Mr. MURPHY. That would be important if we get those——

Ms. KING. I believe that we have some information on that, sir.

Mr. MURPHY. Yes? You do, Ms. King? If you can get that to us——

Ms. KING. We do.

Mr. MURPHY. Do you know anything offhand or can you get those to us?

Ms. KING. I don't remember off the top, but I can tell you that most of the people—we did some work on 2010 data that came out I think in 2012—most of the people who are investigated for fraud, both criminally and civilly, those actions do not go forward. On the criminal side, only about 15 percent of the investigations actually result in the action going forward.

Mr. MURPHY. What is that percent?

Ms. KING. 15 percent.

Mr. MURPHY. 15 percent? Only 15 percent actually go forward to some criminal prosecution?

Ms. KING. Yes.

Mr. MURPHY. Are the rest somehow settled or does that mean you have an 85 percent chance of getting away with it?

Ms. KING. No, that is the settlements. You know, some investigations just do not go forward for a host of reasons.

Mr. MURPHY. OK. So for example, they are not really guilty of fraud or if there is no fraud charges there. Is that what that is—am I correct in that?

Ms. KING. Well, there are no fraud charges finally brought or there is no settlement.

Mr. MURPHY. I guess what we want to know, if someone is—there is a fraud charge, what is the likelihood they are going to see the inside of a prison cell or pay a fine? The rate of success?

Ms. KING. I believe we have some high-level data on what the results are not bound to the length of the sentence but the types of penalties imposed.

Mr. MURPHY. We would like to—Ms. DeGette, do you have a quick question?

Ms. DEGETTE. I just have a follow-up. Mr. Cantrell, the IG identified problems with Medicare C and D plans not reporting data and recommended that the CMS make the reporting mandatory. Is that correct?

Mr. CANTRELL. That is correct.

Ms. DEGETTE. And Dr. Agrawal, has CMS done that?

Dr. AGRAWAL. Well, we have taken a number of steps to better align Medicare C, D and you know, the fee-for-service programs. I talked earlier about the Part D rule that was going to allow us to require provider enrollment in Part D.

We are also working on other activities like the healthcare fraud prevention partnership that actually allows us to exchange data and best practices directly with the private sector so that we can jointly, you know, work to detect and prevent fraud.

Ms. DEGETTE. Right. So I am going to take that answer as a no, you have not made it mandatory, is that right?

Dr. AGRAWAL. We have currently not yet made it mandatory.

Ms. DEGETTE. Yes. Thanks. I think frankly, Mr. Chairman, I think CMS needs to do that because we know there is a lot of fraud in those Part C and Part D programs. I appreciate the efforts that the agency has made on those other ends, but I think making it mandatory would really help. And I appreciate your indulgence, Mr. Chairman.

Mr. MURPHY. Thank you. Mr. Long and Ms. Ellmers have each asked for 1 minute.

Mr. LONG. Just a quick follow-up, Dr. Agrawal. When you were answering Congresswoman Ellmers' questions, you said 70 percent. Are you talking about O&P or are talking about prosthetics? That business? 70 percent of them are not correct on their billing?

Dr. AGRAWAL. No, what I was identifying was that there is a high improper payment rate for DME, but there is also a high improper payment rate in orthotics and prosthetics.

Mr. LONG. OK.

Dr. AGRAWAL. Those are reports that the OIG has also published.

Mr. LONG. OK, because if what my constituent is telling me is accurate, isn't it 93 or 97 percent they go ahead and pay eventually, some time, a couple years from now. The 70 percent didn't match. So I just wanted a clarification on that.

Dr. AGRAWAL. Well, if I could clarify on that point, sir, so of all of the RAC overpayment determinations, only 7 percent are actually overturned on appeal. That is 7. So of all the overpayments that the RACs actually get from providers, 7 percent go onto appeal and at any level of appeal——

Mr. LONG. Yes, but we are talking apples and oranges. We are talking about how many were not improper in the first place is what my question is, not how many were overturned on appeal.

Dr. AGRAWAL. OK. Got you, sir.

Mr. MURPHY. Thank you. Ms. Ellmers, 1 minute.

Mrs. ELLMERS. Thank you, Mr. Chairman. Dr. Agrawal, I have a question, too, about what is the period of time—a provider has an audit and maybe they haven't been educated. I know that you said that there is an effort to educate. Is there a grace period? Is there a time? What time limit from a change that is made to the time that the auditor goes in are we looking at? If something is flagged to, you know, for an audit?

Dr. AGRAWAL. So if I am understanding the question, a change in payment policy that would then——

Mrs. ELLMERS. Right.

Dr. AGRAWAL [continuing]. Downstream be enforced?

Mrs. ELLMERS. Yes. So a change is made. The provider may or may not have had time to—what does CMS consider a reasonable time that that provider should know that a change has occurred?

Dr. AGRAWAL. Sure. So I don't think there is a set time period, the kind of set time period that you are identifying. I will point out that a lot of the audits——

Mrs. ELLMERS. So the change could be made and the next day the auditor can be in the office?

Dr. AGRAWAL. It is typically not like that. The majority of audits that we conduct are around rules and policies that are very well known by the provider community. So the high improper payment rates in DME for example are based on documentation requirements that have been around for a while.

Mrs. ELLMERS. OK. So that is not what I am hearing from my constituents. My constituents are looking at the situation. They are saying, look, we weren't even aware of that change. Ms. King, is that something GAO has recommended, that there be a grace period time or anything like that?

Ms. KING. It is not an issue that we have looked at.

Mrs. ELLMERS. OK.

Ms. KING. But you raise an interesting question about education of providers about the documentation requirements and the rules.

Mrs. ELLMERS. One last question, Dr. Agrawal. You did say that one of the things that you are suggesting in the change in the next RAC audit time period is the idea that those are rewarded. What would you say the percentage, if you have got a low denial rate? Throw out a number.

Dr. AGRAWAL. I don't have a specific number. You know, we can actually get that for you based on the——

Mrs. ELLMERS. Well, I would like to work with you——

Mr. MURPHY. Thank you.

Mrs. ELLMERS [continuing]. On that. Thank you so much, and thank you, Mr. Chairman.

Mr. MURPHY. Dr. Burgess, you have some concluding questions?

Mr. BURGESS. Thank you, Mr. Chairman. OK. Well, I want to go back for a minute to the article, the Bloomberg article, that I referenced that was published on April 28th of this year. Doctors get millions from Medicare after losing their licenses. And this article goes through sometimes in rather painful detail of how a doctor would lose their license in one state and then be able to bill Medicare in another state. I realize that states have a responsibility here as well. But you as the payer for Center for Medicare and Medicaid Services, you ultimately have the responsibility about those dollars going out, and even though New Mexico may have erred in not checking a database for someone who lost their license in Ohio, which was the case of one of the doctors that was referenced here, Medicare paid that doctor an additional $660,000 for that doctor to treat patients in New Mexico. You know, the question is, why won't CMS at least do the basics on checking with the National Practitioner Data Bank to see if there is a problem with this doctor's license?

Dr. AGRAWAL. Congressman, it is not a question of will, it is a question of authorities. So loss of licensure is one of the best triggers that we have for removing somebody from the Medicare program. If a provider loses their license in one state, however, and they have a license that is active in another state, we are bound by limits of authority about, you know, whether or not we can revoke that person across the entire Medicare program. We can certainly revoke or eliminate any enrollment in the state in which they lost their license. But loss of licensure in one state is not in and of itself a basis for losing enrollment nationally.

Now, if there was something underlying the licensure loss——

Mr. BURGESS. I have to stop you there. I find that absolutely incredulous. A guy loses his license, and some of these doctors were charged with fairly serious crimes. And because they had good lawyers, they were able to keep their license in another state. But I mean, does that at least not trigger some sort of basic curiosity on the part of CMS as to why the doctor lost their license in a given state, what was the crime of which they were accused and should we keep sending them checks for $660,000?

Dr. AGRAWAL. Of course, and I, again, as a physician am very frustrated when loss of licensure in one state is not followed by loss of licensure in all states. We do look at those providers to investigate or understand what they have done. But again, this comes down to due process. If there is just not an authority that we can trigger to cause the revocation, then we simply can't do it. These are the constraints that are placed on us rightfully by taxpayers to make sure we don't go too far.

Mr. BURGESS. I don't want you to go too far, and we have certainly heard from other members about some of the problems when you go too far. But should this at the very least, should this not trigger some type of heightened scrutiny on the bills that are coming in from a doctor who has lost their license in another state because of the death of a patient or because they are charged with a serious crime?

Dr. AGRAWAL. It can absolutely be a risk factor. I don't think that that is what is under contention. I think the real issue is whether we can just revoke summarily across the country for loss of licensure in one state, and that is where there are significant restrictions or limitations in our authority.

Mr. BURGESS. Do you not have the authority for heightened scrutiny? I mean, you paid this guy $660,000. Apparently we weren't scrutinizing very highly.

Dr. AGRAWAL. That may or may not be true. I don't know about the data on that particular case or what the report was. But we can subject providers to medical review based on a multitude of factors. We can certainly do that in these kinds of cases. But again, providers can—as you know as well as I do, providers can lose their licenses for a variety of reasons, some of them having nothing to do with healthcare fraud or the extent of our authorities and concern.

Mr. BURGESS. Yes, but it just raises or begs the question, should the Medicare system be paying those doctors? I mean, should they even be taking care of Medicare patients? The fundamental question, is there a way that you have of debarring someone who has been accused of or been convicted of a fairly serious allegation and lost their license as a consequence?

Dr. AGRAWAL. So we have a specific revocation authority that we utilize on a consistent basis. The OIG has an exclusion authority. GSA has a debarment authority. We utilize as triggers for our actions the GSA debarment list as well as the OIG exclusion list.

Mr. BURGESS. Is that the exclusion list here?

Dr. AGRAWAL. Yes.

Mr. BURGESS. I mean, one of the permissive exclusions is license revocation or suspension. One of the mandatory is conviction on three or more occasions of mandatory exclusion offenses. I mean,

what have you got to do? What have you got to do to lose your ability to bill Medicare and have you guys pay?

Dr. AGRAWAL. Well, I would have to defer exclusion questions to the OIG since we don't put people on the exclusion list.

Mr. MURPHY. The gentleman's time is expired.

Mr. BURGESS. Can we let Mr. Cantrell answer the question?

Mr. MURPHY. Mr. Cantrell?

Mr. CANTRELL. We also have a variety of limitations to our exclusions authority. There are situations—often it is the underlying crime or offense that resulted in the loss of license. But the real vulnerability that we face is we don't have 100 percent of the data that we would need to implement exclusions in 100 percent of the cases where we would have the opportunity and the authority. We have a voluntary reporting system to the OIG from the state boards, from other federal agencies, and so that is an area where we know we have incomplete information. But we get—we currently have 57,000-plus entities and individuals who are excluded, and we exclude over 3,000 every year. So there is a lack of complete data that we have access to, but there is still a great number of exclusions that occur.

Mr. BURGESS. I just have to ask you. Can you not query the National Practitioner Data Bank? Can you?

Mr. CANTRELL. I believe that we can. There were some restrictions on law enforcement access to the National Practitioner Data Bank. I can't speak to whether that is actually a continuing concern or not.

Mr. MURPHY. Let me——

Mr. BURGESS. Can you find out and get me that information, please?

Mr. CANTRELL. Certainly.

Mr. MURPHY. Let me ask in general for that for this committee if Dr. Agrawal, Mr. Cantrell and Ms. King, to the extent you can, you have heard a number of things there. We recognize also that you are aware that there is more information that would be valuable to you to help prescreen out people who have some tendency towards crime. The example I gave before, if someone has robbed a bank or involved with some other fraud that is not Medicare fraud, they can still be involved in this I think raises all of our questions, and Mr. Cantrell, you just said you don't have a lot of data.

If you would please in a timely manner get that data back to the committee, as I was talking to Ms. DeGette, too, as I think this is something I think this committee would be interested in moving forward on some legislation to assist you in that rather than just pay and chase moving forward.

I am going to ask unanimous consent that the members' written opening statements be introduced in the record, and without objection, the documents will be there. Also, in conclusion, I thank all the witnesses and members who participated in today's hearing. I remind members, I am sure many people have some other follow-up questions for you. They have 10 business days to get them to you, and I do ask that you do all agree to respond promptly to the questions. So with that, this committee is adjourned. Thank you.

[Whereupon, at 12:00 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

THE COMMITTEE ON ENERGY AND COMMERCE

Memorandum

June 23, 2014

TO:	Members, Subcommittee on Oversight and Investigations
FROM:	Subcommittee on Oversight and Investigations Staff
RE:	Hearing on "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"

On Wednesday, June 25, 2014, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse."

The Subcommittee is following up on recent laws and reports that either authorize or recommend further actions that could be taken to protect Medicare from errors, fraud, and abuse. The U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) has also intensified efforts to address Medicare fraud, waste, and abuse. The purpose of the hearing is to review key recommendations, assess ongoing efforts, and identify additional actions that could be taken or expedited.

I. WITNESSES

One panel of witnesses will testify at the hearing:

- Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services;
- Gary Cantrell, Deputy Inspector General for Investigations, Office of Inspector General, Department of Health and Human Services;
    - *Accompanied by* Gloria L. Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, Department of Health and Human Services; and,
- Kathleen M. King, Director, Health Care, U.S. Government Accountability Office.

II. BACKGROUND

Since 1990, the Government Accountability Office (GAO) has designated Medicare as a Federal program at high risk for fraud and abuse.[1] As noted by GAO and others, Medicare's vulnerability to fraud and abuse arises from the program's size, complexity, decentralization, and administrative requirements. Other emerging trends, such as the expansion of electronic medical records, also increase the vulnerability.[2]

In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion, and reported some of the largest improper payments among Federal programs.[3] The Centers for Medicare and Medicaid Services has estimated that improper payments in the Medicare program were almost $50 billion in fiscal year (FY) 2013, about $5 billion higher than in 2012.[4] In its FY 2013 Agency Financial Report, the HHS reported $36 billion in improper payments for Medicare Fee-for-Service, $11.8 billion for Medicare Advantage (Part C), and $2.1 billion for Medicare Prescription Drug Benefits Program (Part D).[5] While the Department reported reductions in improper payment rates for 5 of the programs (including Part C), there also were reported increases in gross improper payment rates for Fee-for-Service (from 8.5 percent in FY 2012 to 10.1 percent in FY 2013) and Part D (from 3.1 percent in FY 2012 to 3.7 percent in FY 2013).[6] By having a Fee-for-Service improper payment rate that exceeded 10 percent, HHS did not comply with one of the requirements of the Improper Payments Information Act of 2002, as amended.[7]

Although estimates of the dollar amount lost to health care fraud can vary greatly, the full extent of the problem is unknown.[8] However, several analysts agree that tens of billions of dollars are lost every year.[9] The most common types of fraud include: billing for services that were not performed or billing for a higher level of service than was performed; billing for equipment that was not delivered; the use of another individual's Medicare card to obtain care, supplies, or equipment; and billing for home medical equipment after it was returned.

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[1] Testimony of Kathleen M. King, GAO, before the House Committee on Ways and Means, Subcommittee on Health, April 30, 2014. See also, GAO, High-Risk Series: An Update, GAO-13-283, (February 2013).

[2] Fred Schulte, "Growth of electronic medical records eases path to inflated bills," Center for Public Integrity, September 19, 2012. Reed Abelson, Julie Creswell, and Griff Palmer,"Medicare Bills Rise as Records Turn Electronic," New York Times, September 21, 2012. JASON, The MITRE Corporation, "A Robust Health Data Infrastructure," prepared for Agency for Healthcare Research and Quality, AHRQ Publication No. 14-0041-EF, April 2014, at 56: "Paradoxically, initial launches of local and regional EHR systems have generally been met with increases in health care costs, rather than the decreases one might expect if fraudulent activity were more transparent." JASON is an independent scientific advisory group run through the MITRE Corporation, and the name is sometimes explained as an acronym for "July August September October November."

[3] King-GAO testimony, *supra* note 1 at 1-2.

[4] *Id.*

[5] Testimony of Gloria L. Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, U.S. Department of Health and Human Services, before the House Committee on Ways and Means, Subcommittee on Health, April 30, 2014.

[6] *Id.* at 2.

[7] *Id.* at 3.

[8] King-GAO testimony, *supra* note 1 at 1.

[9] The Federal Bureau of Investigation (FBI) refers to estimates of 3-10% of all health care billings as potentially fraudulent. *See* Annual Financial Crimes Report available at http://www.fbi.gov/publications/financial/fcs_report2008/financial_crime_2008.htm#health.

Fraud also may involve payments made to beneficiaries who obtain their Medicare number for fraudulent billing purposes. According to the HHS Office of Inspector General (OIG), between 2009 and 2011, CMS mistakenly paid $190 million in health care payments, including: $23 million to dead people;[10] $92 million to "unlawfully present" persons;[11] $34 million to service providers for beneficiaries who were in jail, even though prisons typically provide for the medical care of inmates;[12] and $40 million on prescription drug subsidies for undeserving beneficiaries.[13]

CMS recently has intensified its efforts to combat fraud, waste, and abuse in the Medicare program. Pursuant to the Patient Protection and Affordable Care Act (PPACA), CMS implemented categorical risk-based screening of providers and suppliers who want to participate in the Medicare program starting in March 2011.[14] The enhanced screening requires certain categories of providers and suppliers that historically have a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare.[15] The existing 1.5 million Medicare suppliers and providers have been subjected to new screening requirements since March 2011. CMS also is collaborating with States "to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to replicate their scams in another State's Medicaid program."[16]

Under the PPACA, the Secretary has authority to impose a temporary moratorium on the enrollment of Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, if the Secretary determines the moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs. During the last year, CMS has used this authority

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[10] Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011, OEI-04-12-00130, October 30, 2013, available at http://oig.hhs.gov/oei/reports/oei-04-12-00130.asp.

[11] Medicare Improperly Paid Providers Millions of Dollars for Unlawfully Present Beneficiaries Who Received Services During 2009 Through 2011, A-07-12-01116, January 23, 2013, available at https://oig.hhs.gov/oas/reports/region7/71201116.asp. OIG identified more than $26 million in improper payments under Part C to unlawfully present beneficiaries. See Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012, A-07-13-01125, April 23, 2013, available at http://oig.hhs.gov/oas/reports/region7/71301125.asp. OIG identified more than $29 million in gross drug costs related to unlawfully present Part D beneficiaries. Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011, A-07-12-06038, October 30, 2013, available at http://oig.hhs.gov/oas/reports/region7/71206038.asp.

[12] Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011, A-07-12-01113, January 23, 2013, available at http://oig.hhs.gov/oas/reports/region7/71201113.asp.

[13] For example, OIG found Medicare paid almost $12 million for prescription drug costs for incarcerated beneficiaries. Medicare Improperly Paid Providers Millions of Dollars For Prescription Drugs Provided To Incarcerated Beneficiaries During 2006 Through 2010, A-07-12-06035, January 2014, available at http://oig.hhs.gov/oas/reports/region7/71206035.asp. OIG also identified more than $29 million in gross drug costs related to unlawfully present Part D beneficiaries. Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011, A-07-12-06038, October 30, 2013, available at http://oig.hhs.gov/oas/reports/region7/71206038.asp.

[14] Statement of Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services before the House Ways and Means Subcommittee on Health, April 30, 2014.

[15] *Id.*

[16] *Id.*

to impose temporary moratoria on the enrollment of new home health agencies and ambulance companies in several "fraud hot spot" metropolitan areas of the country.[17]

Pursuant to the Small Business Jobs Act of 2010, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. CMS reports that the models in the FPS have led to administrative actions, such as the use of revocation authority to remove bad actors from the Medicare program. In calendar year (CY) 2012, CMS revoked 11,279 providers from Medicare, a significant spike from the 2,783 revocations in CY 2011. In CY 2013, CMS revoked 3,807 providers.[18] As reported in the FPS FY 2012 Report to Congress,[19] in its first year of implementation, the FPS stopped, prevented, or identified an estimated $115.4 million in improper payments. CMS has touted the Fraud Prevention System as a way of ending "pay and chase." However, the CMS report to Congress on the second year of implementation of FPS was due October 1, 2013, and still has not been issued.

Notwithstanding these efforts, concerns continue to be raised about a permissive approach that allows providers with questionable backgrounds to keep billing taxpayers. For example, Bloomberg reported that at least 7 doctors who had lost a medical license because of misconduct collected a total of $6.5 million from Medicare in 2012.[20] Another analysis found that doctors who had been charged with Medicare fraud over the last 16 months were paid $17 million of taxpayer money in 2012.[21] In a November 4, 2013 letter to CMS, Chairman Thomas R. Carper and Ranking Member Tom Coburn of the Senate Homeland Security and Governmental Affairs Committee said that their committee staff identified 16 physicians who were enrolled in the Medicare program and who have been convicted of a crime that requires CMS to exclude the individual from participation in Medicare.[22] The Senate Committee found 5 more such doctors days after the letter.[23] As of last week, Majority staff for the House Energy and Commerce Committee found that 11 of the 21 physicians on the Senate Committee list still were not excluded.

Finally, Majority Committee staff identified at least 14 individuals convicted of FDA-related crimes currently debarred by the FDA, but do not appear to be excluded from Medicare.[24]

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[17] *Id.* at 4. These areas are: Miami, Chicago, Houston, Fort Lauderdale, Detroit, Dallas, and Philadelphia (on ground ambulances).

[18] April 30, 2014 letter from Shantanu Agrawal, MD, CMS to House Energy and Commerce Committee requestors.

[19] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf.

[20] David Armstrong and Caroline Chen, "Doctors Get Millions From Medicare After Losing Their Licenses," Bloomberg, April 28, 2014.

[21] Jonathan Easley and Elise Viebeck, "Indicted docs got Medicare millions," The Hill, April 10, 2014.

[22] Letter from Chairman Thomas R. Carper and Ranking Member Tom A. Coburn, M.D., Senate Committee on Homeland Security and Governmental Affairs, to The Honorable Marilyn Tavenner, Adminstrator, CMS, November 4, 2013.

[23] Dan Mangan, "Senators: Medicare felons on 'OK-to-pay' list despite ban," cnbc.com, December 16, 2013, available at http://www.cnbc.com/id/101276154.

[24] The OIG exclusion database does not show past exclusions and reinstatements. The database also does not list the length of time of the exclusion. There is no public record of the exclusion length because many people do not get reinstated right away and remain excluded. According to the OIG, the list would be ambiguous if it listed the term; people would assume the exclusion is lifted after the period of years.

In one case, a doctor who pled guilty to injecting more than 800 victims with unapproved Botulinum toxin was both excluded and debarred. However, the co-defendant nurse who also pled guilty, with a one-year prison sentence and a FDA debarment, is not excluded under either her FDA-debarred name or alias.[25] In addition, staff identified a doctor who pled guilty to an FDA-related mail fraud felony in 2007, was permanently debarred by FDA in 2009, but is not excluded from Medicare and received over $86,000 in Medicare payments in 2012.[26] Staff also identified 4 other doctors who entered guilty pleas in the 2006-08 period, were debarred by FDA before or during 2012, but who received over $900,000 in Medicare payments in 2012. Another doctor who entered a guilty plea in 2002, whose FDA debarment was in effect during 2012, received over $38,000 in Medicare payments in 2012. All told, staff identified from the FDA debarment list that there were 6 doctors with guilty pleas entered before 2009, and debarred by FDA, who received over $1 million in Medicare payments in 2012.[27]

According to OIG staff, the Medicare exclusion database contains about 57,000 names, adds about 3,200 – 3,500 names each year, and reinstates about 600 names each year.[28] Although the exclusion program was established more than three decades ago, OIG staff members were not aware of any recent audits or evaluations of the program.[29] The exclusion database receives information from required, direct referrals from OIG investigations and Medicare Fraud control units, and voluntary information from Federal (FBI, DEA, VA), State, and local law enforcement.[30]

The OIG announced that in FY 2013, its fraud, waste, and abuse prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in a record-breaking recovery of $4.3 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers.[31] Over the last 5 years, these enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period.[32] Over the last 3 years, the average investment of the HCFAC program is $8.10 for every dollar spent, which is an increase of $2.70 over the average ROI for the life of the HCFAC program since 1997.[33] However, due to reduced funding, OIG is currently in a hiring freeze and has lost over 200 people over the past two years. As a result, OIG has fewer resources available to fight Medicare and Medicaid fraud. Due to lack of resources, OIG has closed over 2,200 investigative complaints, and by the end of FY 2014, the OIG expects to reduce Medicare and Medicaid oversight by 20 percent.[34] OIG already has lost 20 percent of its Strike Force agents. An independent report noted that this reduction in OIG fraud detection staff, corresponds to about one fourth of its employees in this area, and is in opposition to the intended goal of an

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[25] OIG reported to staff that this individual had been excluded for seven months, and then was reinstated.
[26] OIG confirmed to staff that there was no record of an exclusion under the name of this doctor.
[27] OIG confirmed to staff that there was no record of an exclusion under each of the names of these individuals.
[28] OIG staff briefing for House Energy and Commerce Committee bipartisan staff, June 19, 2014.
[29] *Id.*
[30] *Id.*
[31] http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf.
[32] Agrawal-CMS, supra note 14 at 1.
[33] *Id.*
[34] Joe Carlson, "HHS inspector general's funding cuts will hurt fraud probes," Modern Healthcare, July 26, 2013, available at http://www.modernhealthcare.com/article/20130726/NEWS/307269996.

HHS initiative to prevent health care fraud.[35] The report also found that "[t]his reduction in staff is likely to reduce actions taken by CMS in response to their existing predictive analytics software that is designed to spot patterns of fraud."[36]

While CMS has taken many actions, the GAO and the OIG have found that CMS has not fully implemented other actions authorized by the PPACA.[37] These unimplemented actions include:

- *Surety Bonds*: PPACA authorized CMS to require a surety bond for certain types of at-risk providers and suppliers. The bonds also could serve as a source for recoupment of erroneous payments. CMS reported in April 2014 that it had not scheduled for publication a proposed rule to implement the surety bond requirement.

- *Providers and Suppliers Disclosure*: CMS has not scheduled a proposed rule for publication for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, as authorized under the PPACA, such as whether the provider or supplier has been subject to a payment suspension from a Federal health care program.

- *Compliance Program*: CMS has not established the core elements of compliance programs for providers and suppliers.

GAO also recommended that CMS increase its use of automated prepayment edits to prevent improper payments and strengthen post-payment review to identify and recoup improper payments.[38] GAO noted in April 2014 that CMS had addressed "some" of these recommendations.[39] GAO has made multiple recommendations to CMS to remove Social Security numbers from beneficiaries' Medicare cards to help prevent identify theft, but CMS has not taken action on these recommendations.[40] HHS has agreed with the recommendations, but reported CMS could not proceed for several reasons, including funding limitations.

In reports and in testimony, the OIG has issued numerous recommendations to improve CMS's Medicare oversight. Among the key recommendations are:

- Implement policies and procedures to detect and recoup improper payments made to unlawfully present and incarcerated beneficiaries.
- Identify and recoup improper payments made on behalf of entitlement-terminated beneficiaries and establish policies and procedures to prevent additional improper payments.
- Improve existing safeguards to prevent payments to deceased beneficiaries.

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[35] JASON report, supra note 2 at 56.
[36] *Id.*
[37] See GAO testimony, *supra* note 1, and HHS OIG testimony, *supra* note 5.
[38] GAO testimony, *supra* note 1.
[39] *Id.*
[40] *Id.* at16.

- Require mandatory reporting by Part C and Part D plans of potential fraud and abuse incidents, and use the data from the reporting for monitoring or oversight purposes.

The OIG testified in April 2014 that more action is needed from CMS.[41]

The April 2014 JASON Report, prepared for the Agency for Healthcare Research and Quality, found that "[e]lectronic access to health data will make it easier to identify fraudulent activity, but at present there is little effort to do so using EHRs."[42] The report recommended: "Large-scale data mining techniques and predictive analytics should be employed to uncover signatures of fraud. A data enclave should be established to support the ongoing development and validation of fraud detection tools to maintain their effectiveness as fraud strategies evolve."[43]

III. ISSUES

The following issues will be examined at the hearing:

- Is CMS implementing the outstanding GAO, OIG, and JASON Report recommendations to strengthen Medicare oversight? What is the status of implementation?
- What additional sets of data can be made available and shared to prevent Medicare fraud, waste, and abuse?
- Is CMS using all the tools at its disposal to mitigate vulnerabilities to the Medicare program?
- How is CMS using State data captured by the Federation of State Medical Boards that could be used as an early-warning system to flag bad providers?

IV. CONTACTS

If you have any questions about this hearing, please contact Alan Slobodin, Sean Hayes, or Emily Newman at (202) 225-2927.

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[41] HHS-OIG testimony, *supra* note 5.
[42] JASON Report, *supra* note 2 at 57.
[43] *Id.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of the Secretary

Office of Medicare Hearings and Appeals
Office of the Chief Judge
1700 North Moore Street, Suite 1800
Arlington, VA 22209
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DEC 2 4 2013

Memorandum to OMHA Medicare Appellants

Re: Administrative Law Judge Hearings for Medicare Claim and Entitlement Appeals

Based on a number of recent inquiries regarding delays in the processing of Medicare claim and entitlement appeals, I want to apprise you of some recent operational changes that may impact your interaction with the Office of Medicare Hearings and Appeals (OMHA). You have been chosen to receive this letter because you have a significant number of Medicare appeals currently pending before OMHA.

Due to the rapid and overwhelming increase in claim appeals, effective July 15, 2013, OMHA temporarily suspended the assignment of most new requests for an Administrative Law Judge hearing to allow OMHA to adjudicate appeals involving almost 357,000 claims for Medicare services and entitlements already assigned to its 65 Administrative Law Judges. This temporary measure was necessitated by a dramatic increase in the number of decisions being appealed to OMHA, the third level of administrative review in the Medicare claim and entitlement appeals process.

From 2010 to 2013, OMHA's claims and entitlement workload grew by 184% while the resources to adjudicate the appeals remained relatively constant, and more recently were reduced due to budgetary sequestration. Even with increased productivity from our dedicated Administrative Law Judges and their support staff, we have been unable to keep pace with the exponential growth in requests for hearing. Consequently, a substantial backlog in the number of cases pending an ALJ hearing, as well as cases pending assignment has resulted.

In just under two years, the OMHA backlog has grown from pending appeals involving 92,000 claims for services and entitlement to appeals involving over 460,000 claims for services and entitlement, and the receipt level of new appeals is continuing to rise. In January 2012, the number of weekly receipts in our Central Operations Division averaged around 1,250. This past month, the number of receipts was over 15,000 per week. Due to this rapidly increasing workload, OMHA's average wait time for a hearing before an Administrative Law Judge has risen to 16 months and is expected to continue to increase as the backlog grows.

Although assignment of most new requests for hearing will be temporarily suspended, OMHA will continue to assign and process requests filed directly by Medicare beneficiaries, to ensure their health and safety is protected. Assignment of all other new requests for hearing will resume as Administrative Law Judges are able to accommodate additional workload on their dockets. However, with the current backlog we do not expect general assignments to resume for at least 24 months and we expect post-assignment hearing wait times will continue to exceed 6 months.

We remain committed to providing a forum for the fair and timely adjudication of Medicare claim and entitlement appeals; however, we are facing significant challenges which reduce our ability to meet the timeliness component of our mission. To address this challenge, OMHA is working closely with our colleagues within the Centers for Medicare and Medicaid Services (CMS) and the Departmental Appeals Board (DAB). We are committed to finding new ways to work smartly and more efficiently, in order to better utilize resources to address the increased demand for hearings.

In order to keep you apprised concerning our workload and to facilitate your interaction with OMHA, we will host an OMHA Medicare Appellant Forum on February 12, 2014, from 10:00 am to 5:00 pm. The event will take place in the Wilbur J. Cohen building located at 330 Independence Ave. SW, Washington DC 20024. The purpose of this event is to provide further information to OMHA appellants and providers on a number of initiatives underway and to provide information on measures we can take to make the appeals process work more efficiently. You can obtain further information and register for the event by visiting the OMHA website; http://www.hhs.gov/omha/index.html. We are pleased to offer this opportunity and hope you will be able to join us.

Although we know that this information will not alleviate your concerns with regard to delays in processing appeals, we hope that we have at least provided a backdrop for the environment in which OMHA currently processes appeals. We ask for your indulgence as we work to address these challenges and thank you in advance for your patience as we continue our efforts to serve the Medicare appellant and beneficiary communities. For additional information and updates on OMHA's adjudication timeframes, or to register for our OMHA Medicare Appellant Forum, please visit the OMHA website at: http://www.hhs.gov/omha/index.html.

Sincerely,

Nancy J. Griswold
Chief Administrative Law Judge

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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July 18, 2014

Dr. Shantanu Agrawal
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Agrawal:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, June 25, 2014, to testify at the hearing entitled "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, August 1, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Shantanu Agrawal, M.D.
Deputy Administrator and Director,
Center For Program Integrity
Centers For Medicare & Medicaid Services
"Provider Screening"
United States House Committee On Energy & Commerce
Subcommittee On Oversight & Investigations
June 25, 2014

Attachment 1—Additional Questions for the Record

The Honorable Tim Murphy

1. **What percentage of Recovery Audit Contractors (RAC) appeal cases in FY 2013 were decided on the record?**
2. **Who are the top ten administrative law judges that are deciding RAC cases on the record?**
3. **What is being done to implement Office Inspector General (OIG) recommendations to improve the Administrative Law Judge (ALJ) process, including better training and clarification of Medicare policies, so ALJ RAC rulings are more in line with those made at the two earlier levels of appeal, the Medicare Administrative Contractors (MAC) and the Qualified Independent Contractors (QIC)?**
4. **What plans are in place to hire additional judges at the ALJ level to deal with the Office of Medicare Hearings and Appeals (OMHA) appeal backlog?**

Answer to #1 - #4: The Office of Medicare Hearings and Appeals (OMHA) is independent from CMS, so CMS cannot speak to these issues.

5. **Dr. Agrawal said "We want to get the RACs up and running as quickly as possible." What is delaying the award of new RAC contracts that are not under protest?**

Answer: Recovery Audit Regions 1, 2, and 4 are subject to a bid protest in the Court of Federal Claims. Recovery Audit Regions 3 and 5 are based on the same statement of work. Therefore, we believe it is prudent to receive the Judge's decision prior to moving forward on the procurement.

6. **What is being done to monitor the quality of the Administrative Law Judges' decisions and ensure they consistently adhere to current Medicare policy?**

Answer: Because OMHA is independent from CMS, I cannot speak to their efforts to monitor decisions made by ALJs.

7. What is being done to insure the RACs are notified of the ALJ hearings?

Answer: In accordance with the regulation in 42 CFR 405.1020(c), Notice of Hearing, Administrative Law Judges issue a Notice of Hearing to all the parties to the initial determination and the Qualified Independent Contractor (QIC) that issued the reconsideration decision if a hearing is held. The QICs are contractually required to forward the Notice of Hearing to the Medicare Administrative Contractors, Recovery Auditors, and Zone Program Integrity Contractors. The current Joint Operating Agreements between the QICs and these entities establish timeframes and transmission mechanisms.

When issues arise, such as delays or non-receipt of Notices of Hearings, CMS brings them to OMHA's attention during a regularly scheduled bi-weekly meeting.

8. CMS is expanding the savings for the FPS to include savings associated with payment suspensions and savings associated with revocations. CMS' traditional Medicare Integrity Program (MIP) Return On Investment (ROI) does not include these types of savings. Why is CMS making a change with this methodology?

Answer: The Small Business Jobs Act of 2010 requires the Secretary of HHS to submit reports for each of the first three years of Fraud Prevention System (FPS) implementation. The law also requires the Office of Inspector General (OIG) to certify the actual and adjusted savings with respect to improper payments recovered and avoided and the return on investment related to the Department's use of the FPS for each of its first three implementation years. Including payment suspensions and savings associated with revocations was the result of consultation with the OIG on the actual and adjusted savings resulting from the FPS. This methodology currently only applies to the FPS, and has not been expanded to the Medicare Integrity Program return on investment methodology.

9. The Small Business Jobs Act of 2010 provided CMS with $100 million to implement the Fraud Prevention System (FPS). If I recall correctly, the initial contract with option years was $70 M. Based on the information in the first report and in this report, CMS has or is about to spend the initial $100 million. What is the burn rate and the funding plan moving forward? Please provide a detailed chart with all costs (technology, manpower, legal, actual savings return based on enhanced edits, etc.).

Answer: CMS implemented the FPS on June 30, 2011. In the first implementation year, the FPS stopped, prevented, or identified an estimated $115.4 million in improper payments. In the second implementation year, the FPS identified or prevented more than $210 million in improper Medicare fee-for-service (FFS) payments, double the previous year.

The funding for FPS is associated with two main contractors, Northrup Grumman (Development Contractor) and IBM (Modeling Contractor). In addition to these contractors, National Government Services (NGS) and Verizon are actively involved as sub-contractors. The table below represents funding amounts associated with development and modeling efforts:

Period Of Performance	Total Funding (Development + Modeling)
05/11 - 07/11	$7,209,714
07/11 - 07/12	$23,282,595
07/12 – 07/13	$34,848,069
07/13 - 07/14	$35,213,285
07/14 - 07/15	$22,700,383
Total Funding: 05/11 - 07/15	**$123,254,046**

The funding includes the following categories:

Type of Contractor	Category	Included
Development	Hardware/Software/System	Hardware infrastructure, Hardware hosting, Software Licenses, System Patches, Software Development/Implementation
Development	User/Business Oversight	Model Development, Vulnerability Identification, Testing, Training, Help Desk Support
Development	Monitoring	Model/Edit Monitoring, System Performance
Modeling	User/Business Oversight	Model Development, Testing, Vulnerability Identifications, and Model Monitoring
Modeling	Monitoring	Model Monitoring, System Performance

The costs above the initial $100 million appropriated for the Fraud Prevention System are funded through Medicare Integrity Program resources.

10. The Small Business Jobs Act says that "the Secretary shall expand the use of predictive analytics technologies, beginning April 1, 2015, to apply to Medicaid and CHIP. To the extent the Secretary determines appropriate, such expansion may be made on a phased-in basis." Will you commit to keep this Committee updated on what CMS is thinking as that date approaches?

Answer: CMS is happy to work with the Committee to provide updates on the progress of the FPS. The Small Business Jobs Act requires that CMS include in the Third Implementation Year Report an analysis of the cost-effectiveness and feasibility of expanding the use of predictive analytics technologies to Medicaid and CHIP. Section 4241(c)(5) of the Small Business Jobs Act does refer to expanding the use of predictive analytics technologies to Medicaid and CHIP, but only "[b]ased on the results of the report and recommendation required under subsection (e)(3)."

Although Medicaid is administered and organized in a distinctly different way than Medicare, CMS anticipates that there are opportunities to transfer the knowledge and lessons learned about Medicare through the FPS to states for uses applicable to Medicaid. CMS will report to the Congress as required by section 4241(e)(3) on the cost-effectiveness and feasibility of expanding

use of predictive analytics technologies to Medicaid and CHIP. However, data provided to CMS on Medicaid payments are post-payment, so it will be important to consider whether prepayment analytics may best be implemented by the states.

11. CMS has said "the Fraud Prevention System now has the capability to stop payment of certain improper claims, without human intervention, by communicating a denial message to the claims payment system." This sounds promising. Has CMS actually used this capability yet? If so, how many claim denials has it resulted in?

Answer: CMS launched an Ambulatory Surgical Center edit in one state as a proof of concept to test the functionality of rejecting claims directly through the Fraud Prevention System. CMS successfully rejected 125 claims for 52 providers during the proof of concept, totaling over $40,000. While the savings may be small for this single edit in one state, CMS intends to expand the number of edits in the third implementation year.

12. CMS said it "has pilot projects underway evaluating the expansion of programs that provide waste, fraud and abuse leads to Medicare Administrative Contractors for early intervention." Two questions on this:

a. Please explain the duration of the pilot, the evaluation process, and the timeframe in which this Committee can expect to know from you what actions you may take as a pilot.

b. How would this effort to work with MACs duplicate – or not duplicate – the work of the other program integrity contractors?

Answer: CMS completed the pilot during the second implementation year, and CMS has begun additional pilot testing, and results will be included in the report to Congress on the third implementation year. The purpose of the pilot was to determine whether providers identified in the FPS that were not currently in the workload of the Zone Program Integrity Contractors were submitting a high number of likely improper payments. The first phase that was completed during the second implementation year had positive results.

CMS identified eight providers and suppliers ("providers") for the pilot, and the Medicare Administrative Contractors (MACs) implemented a two-phase intervention. First, the MAC contacted individual providers to discuss their billing data. If the provider did not have a satisfactory explanation for their aberrant billing pattern or did not change their billing pattern, the provider's claims were placed on prepayment review. Four of the eight providers the MAC contacted changed their billing within one month. Two others were instructed to complete a self-audit, and the remaining two did not change their billing patterns. One of those providers is now on prepayment review, and the other is subject to post pay review.

The MACs cited the speed with which the billing behavior was changed and the low cost of the intervention as positive outcomes of the pilot. The cost of the intervention is reduced because there were no additional costs for the analysis and 4 providers changed their behaviors based on a conversation rather than the traditional approach of reviewing medical records first, which must be completed by clinical staff. Since this was a small, short-term project the long-term impact cannot be quantified, however the initial results are promising.

Another value of expanding the use of the FPS tool is that the MAC and Zone Program Integrity Contractor (ZPIC) may be able to better coordinate audit activity on a specific provider, rather than duplicating work. This will reduce burden on providers and provide a forum for collaboration across contractors.

13. CMS said the FPS "resulted in CMS taking action against 938 providers and suppliers." Can you give us a breakdown of the types of actions taken against different types of providers?

Answer:

Administrative action	**Number of Providers** Unduplicated Oct 2012 – Sept 2013
Prepayment Review Denials	423
Denials from Auto-Denial Edits	254
Payment Suspension	35*
Overpayments Referred to the MAC for Recovery	235
Referred to Law Enforcement	75
Revocation	48
Total	**938**

* These 35 providers were on active payment suspension as of the last day of the reporting period. An additional 20 providers were on payment suspension during the reporting period but were terminated from payment suspension prior to the end of the reporting period.

14. In tallying the adjusted ($54 million) or unadjusted ($210 million) Medicare dollars, how did CMS account for the role of its ZPICs, PSCs, or other program integrity contractors? Were the findings of the contractors counted toward the dollar amount identified? If so, how was the PSC's normal work disaggregated from its work for the FPS?

Answer: CMS accounted for the role of the contractors in the methodology certified by the HHS Office of Inspector General. CMS requires its contractors to track the recoveries that result from FPS leads, and OIG then determined that our methodology for tracking was reasonable, and certified those savings. In addition to identifying new leads and new issues, FPS information may corroborate, augment or expedite investigations. CMS identified or prevented an additional $39.4 million using information in the FPS to corroborate, augment, or expedite existing investigations but for which documentation was insufficient to be included by the OIG in the certified savings.

An estimated portion of the contractor time is included since a portion of time is spent acting on FPS leads. These costs are estimated by calculating the percentage of total investigation created from FPS leads, including the new leads in the second year, new leads in the first year that were also worked in the second year and existing investigations where administrative action was taken due to FPS, and multiplying that percentage by their total investigator costs.

15. Before the creation of the FPS that Congress mandated CMS adopt, CMS was reluctant to adopt more forward leaning, predictive tools. I am not asking you to agree with this characterization, but it was the perception of many in Congress that CMS did not think they needed the FPS, and resisted being told how to do this program. However, Congress mandated it, and here you are today explaining the achievements of FPS. Do you think the FPS has been a positive step for CMS and taxpayers? Mr. Chairman, I would note the role of former Florida Republican Senator George LeMieux, who, as author of the provision creating FPS, deserves credit for helping nudge CMS's fraud-fighting efforts forward to adopt the FPS.

Answer: Yes, I agree that the FPS has been a positive step. It's part of CMS's comprehensive program integrity strategy and its implementation has resulted in a positive return on investment for Medicare and taxpayers. For example, the FPS is used as part of an agency focus on home health services in South Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. The FPS led to investigations and administrative actions, which ultimately led to the revocation of the billing privileges of home health agencies, with potential savings worth more than $26 million. CMS expects that future activities will substantially increase savings by expanding the use of the innovative technology beyond the initial focus on identifying fraud into areas of waste and abuse.

16. What number of full-time-equivalent (FTE) personnel are at CMS or its contractors, who are charged with identifying, reducing, or recovering improper payments attributable to fraud, waste, or abuse? Could you please provide the Committee with this number? Please include the personnel at Office of Financial Management who oversee the Recovery Audit Contractors, the contract staff of program integrity contractors, the FTE at the Center for Program Integrity, and any other relevant personnel.

Answer: CMS has 512 full-time employees whose work includes identifying, reducing, or recovering improper payments. Additionally, CMS contractors employ 1,265 full-time employees for this work.

17. Almost two years ago exactly, with a press release, HHS and DOJ announced a public private partnership to help prevent health care fraud. I think collaboration with industry and the private sector is the kind of initiative most members would support. However, it's been two years, and what we have heard from many in the industry is that CMS has been moving, but moving slowly. Can you please outline for the Committee what the partnership has accomplished to date, and what are the metrics for success? Could you please provide the Committee —in as much detail as possible— with the following:

- **a. The number of cases shared between plans and CMS**
- **b. The number of trends shared between plans and CMS**
- **c. What types of corrective actions CMS may have taken as a result of the partnership?**
- **d. Has CMS identified any real or perceived legal barriers to plans and CMS sharing information?**

e. In your view, are there any outstanding legal barriers to plans and CMS sharing needed information to prevent fraud, waste, or abuse?

Answer: The Healthcare Fraud Prevention Partnership (HFPP) is a ground-breaking initiative that is designed to work with the private sector to fight fraud, waste, and abuse across the health care system. The HFPP's ultimate goal is to exchange facts and information to identify trends and patterns that will uncover fraud, waste and abuse that could not otherwise be identified. CMS is working through the legal requirements for data sharing with private health plans, and has made significant progress in the development of the HFPP.

Until CMS receives approval for its new information collection effort under the HFPP from the Office of Management and Budget, the data sharing has been limited to nine participants. Current information collection activities are limited to a specified number of participants per pilot study under Paperwork Reduction Act requirements. In addition, because claims data contains both personally identifiable information and protected health information subject to many constraints on sharing, these early HFPP proof of concept pilots have used non identifiable data such as payment codes which may be associated with fraud, waste or abuse, or information about known non-operational group practices and other organizational data. Once the legal agreements are put in place to allow for the maximum legally allowable data sharing, the partnership will be able to share provider-level information that should result in joint investigations and sharing of active and past cases.

That said, the HFPP currently has 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. The HFPP has conducted 4 data and information sharing studies over the past two years. Several studies are still being analyzed by the partners and they will report outcomes in the future. CMS has established over 150 payment edits to address improper billing identified through the information shared within the partnership. We have also put several providers on payment suspension, revoked several providers, as well as revoked provider practice locations that we have identified as false store fronts.

18. What do you believe are the top five vulnerabilities with regard to the integrity of Medicaid payments?

Answer: CMS measures Medicaid and CHIP improper payments annually through the Payment Error Rate Measurement (PERM) program, using a 17-state three-year rotation so that CMS measures each state once every three years. Through PERM, CMS samples state Medicaid FFS and managed care payments, collects documentation from providers, conducts a data processing review on sampled FFS and managed care payments, and performs a medical record review on sampled FFS claims.

Based on a compilation of Medicaid improper payments identified in Fiscal Years (FYs) 2011, 2012, and 2013, the PERM program reported FFS payment errors by service type. The top five service areas for FYs 2011-2013, based on projected dollar amount, were found to be in the following services (in decreasing order of dollars in error):

- Habilitation and Waiver Programs
- Nursing Facility/Intermediate Care Facilities

- Prescribed Drug
- Personal Support Services
- ICF for the Mentally Retarded and Group Homes[1]

Through PERM, the identification of service types and other predictors of high payment errors inform corrective actions by CMS and states. CMS works closely with states to review their error rates, determine root causes of errors, and develop corrective actions to address the major causes of errors.

19. Please provide the Committee with an update on the status of using RACs in Medicaid, as required by the ACA.

Answer: State Medicaid agencies contract with Medicaid Recovery Audit Contractors (RACs), to identify and recover overpayments, and identify underpayments made to Medicaid providers. CMS implemented section 6411(a) of the Affordable Care Act in a Final Rule published on September 16, 2011 requiring states to implement Medicaid RAC programs by January 1, 2012, unless granted an exception.

By the end of FY 2013, 45 states and the District of Columbia had implemented Medicaid RAC programs, and CMS had granted five U.S. Territories complete exceptions from implementing RAC programs. Additionally, CMS granted five states time-limited exceptions from implementing Medicaid RAC programs during FY 2013, due to either high rates of Medicaid managed care penetration (two states), small Medicaid beneficiary population and low Medicaid payment error rate (one state), or re-procurement of new State Medicaid RACs (two states). For FY 2013, 19 states reported recoveries totaling $124.3 million in the Federal and state share combined amount (Total Computable) and returned a total of $74.5 million (Federal share).[2]

[1] 2013 PERM Report Appendix 2, Figure S12, available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2013PERMREPORTAPPPENDICES.pdf.

[2] RAC recoveries include overpayments collected, adjusted, and refunded to CMS, as reported by states on the CMS-64.

The Honorable Michael C. Burgess

1. **CMS has not adopted all of the recommendations from HHS OIG to prevent and detect fraud. What recommendations have and have not been adopted? Why have these recommendations not been adopted? What is the timeline for implementing these provisions?**

Answer:

	OIG Recommendation	Status
1	Remove Social Security Numbers from Medicare cards to help protect personally identifiable information of Medicare beneficiaries	Unimplemented CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.
2	Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns	Implemented In June 2013, CMS sent its first pharmacy risk assessment to Part D plans, and CMS has released two other assessments in December 2013 and April 2014 to seek industry comments about the methodology used to help identify high risk pharmacies. On May 19, 2014, CMS issued a Final Rule that permits CMS to direct access to Part D sponsors' downstream entities: This provision will provide CMS, its antifraud contractors, and other oversight agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies and other entities that contract or subcontract with Part D Sponsors to administer the Medicare prescription drug benefit. The provision will streamline CMS' and its anti-fraud contractors' investigative processes. Currently, it can take a long time for CMS' contractors who are often assisting law enforcement to obtain important documents like invoices and prescriptions directly from pharmacies, because they must work through the Part D plan sponsor to obtain this information. This provision is designed to provide more timely access to records, including for investigations of Part D fraud and abuse, and responds to recommendations from the Department of Health and Human

		Services (HHS) Office of Inspector General.
3	Require Part D plans to verify that prescribers have the authority to prescribe	Implemented Through rulemaking finalized in 2012, CMS required Part D sponsors to submit Prescription Drug Events (PDEs – Part D claims data) with active and valid individual prescriber National Provider Identifiers (NPIs) beginning January 1, 2013. CMS began to apply edits to any PDE without an active and valid individual NPI on May 6, 2013. On May 19, 2014, CMS issued a Final Rule that requires prescribers of Part D drugs to enroll in Medicare to help ensure CMS that Part D drugs are only prescribed by qualified individuals. CMS also finalized authority to revoke Medicare enrollment if CMS determines there is a pattern or practice of prescribing Part D drugs that is abusive, ifa Drug Enforcement Administration (DEA) certificate of registration is suspended or revoked, or if the applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the provider's ability to prescribe drugs.
4	Increase monitoring of Medicare claims for home health services	Implemented CMS has implemented the FPS, which runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment, including home health claims. For example, FPS is used as part of an agency focus on home health services, particularly in Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. CMS is monitoring the activity of home health agencies across Florida through the FPS to identify changes in billing patterns and the potential migration of fraud schemes to other parts of the state or Nation.
6	Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements	Unimplemented CMS is evaluating whether or not a form will help resolve the issues identified in OIG's

		report. However, a standardized form would eliminate some of the current flexibilities that providers are afforded. Providers are allowed to use existing information in the medical record, rather than completing a separate form, to document a face to face encounter.
7	Implement the surety bond requirement for HHAs	Unimplemented CMS has not scheduled for publication new regulations under this authority. CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about $1.6 million directly from surety companies, and has collected an additional $18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame.
8	Monitor hospices that depend heavily on nursing facility residents	Implemented CMS has provided this information to the Recovery Auditors and to the Medicare Administrative Contractors, emphasizing the importance of this issue when prioritizing medical review strategies and other interventions.
9	Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary	Ongoing Section 3132 of the Affordable Care Act requires CMS to revise Medicare's payments system for hospice care no earlier than October 1, 2013, and allows CMS to collect additional data and information as the Secretary determines appropriate to revise payments for hospice care. In May 2014, CMS released additional analysis to inform hospice payment reforms.
10	Consider whether additional controls are needed are needed to ensure that Personal Care Services are allowed under the program rules and are provided.	CMS will conduct an analysis of personal care services' requirements and identify potential risks and vulnerabilities relating to the delivery of personal care services. CMS will gather additional data on best practices to better inform states. This information will be used to address the recommendations.
11	Take action to provide states with	After the information in # 10 above is

	data suitable for identifying payments for PCS claims when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.	gathered and reviewed, CMS will determine the appropriate policy and evaluate the best vehicle to communicate the information.
12	Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to potential fraud and abuse.	Unimplemented CMS does not concur with this recommendation. Part D sponsors are held accountable for detecting and preventing fraud and abuse. Amending the regulation to require reporting directly to CMS itself could be considered a duplication that would require Part D sponsors to expend unnecessary additional resources and would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud. Plan sponsors report and share information related to potential fraud, waste and abuse (FWA) through several means which includes the FWA Work Group meetings where information is shared with CMS, law enforcement and other plan sponsors; directly contacting the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC); and by contacting 1-800-MEDICARE which will refer the case to the NBI MEDIC.
13	Establish a deadline for when complete, accurate and timely T-MSIS data will be available.	Implemented In August 2013, CMS issued a State Medicaid Director letter that established a compliance date of July 1, 2014.

2. What databases is CMS currently using to screen provider or fund recipients or to detect other types of fraud in the system? What other databases could CMS be using?

Answer: The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs and CHIP, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid and CHIP providers and suppliers in March 2011. This enhanced

screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare. All Medicare providers and suppliers undergo a baseline screening, including confirmation of the provider's or supplier's Social Security Number through the Social Security Administration, license and certification through the state licensing boards, as well as searches in the System for Award Management, operated by the General Services Administration (GSA), in terms of Government contracting exclusion (suspension and debarments) and the HHS OIG exclusion list for all individuals listed on the application.

Under section 1128 of the Social Security Act, HHS OIG must exclude individuals and entities from Federal health care programs based on felony or misdemeanor convictions related to the Medicare or Medicaid programs, or related to the abuse or neglect of patients, and has discretionary authority to exclude individuals on a number of grounds, including misdemeanor convictions related to health care fraud. Once approved, enrolled providers are systematically compared weekly to the Social Security Administration's complete file of death information and the Medicare Exclusion Database (MED), CMS's repository of information contained in the OIG's exclusion list, and CMS routinely revokes billing privileges based on this information. Revocations are retroactive to the date of a provider's or supplier's respective plea or conviction, and if the provider or supplier submitted claims after that date, CMS demands those payments be repaid.

CMS has historically relied on the MED and GSA list to identify relevant felony convictions because there is not a centralized or automated means of obtaining felony convictions of Medicare providers and suppliers. CMS is currently working on a process to match enrollment data against public and private databases to receive timely felony conviction data. Additionally, in April 2014, CMS announced that upon notification, providers and suppliers designated to the high screening level will be required to submit fingerprint-based background checks to gain or maintain billing privileges for Medicare. The requirement applies to individuals with a five percent or greater ownership interest in a newly-enrolling durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) supplier or a newly-enrolling home health agency (HHA), as well as any provider and supplier that has been subject to certain adverse actions, including prior revocation, payment suspension, or licensure suspension or revocation.

3. **Through the Sunshine Act, CMS is required to include "background information on industry-physician relationships." While access to information about physician-industry relationships is important, the proper context is needed to understand these legitimate interactions between physicians and industry. Will CMS be putting out draft context proposals for public comment? If so, when? If not, why not?**

Answer: CMS agrees that both context and access to information about physician-industry relationships is important to help the consumer understand the information presented. In the preamble to the February 2013 Final Rule implementing the Open Payments program, CMS provided extensive background information on industry-physician relationships. This information discussed how the financial relationships can be beneficial to the advancement of medicine and innovation, however they can also create the opportunity for conflicts of interest. The preamble and the Final Rule discussed that CMS will remain neutral in its representation and presentation of the data, and will not label any reported interactions as legitimate or

inappropriate. CMS solicited and addressed comments to the Final Rule, including the request that CMS allow applicable manufacturers to voluntary report contextual information about each payment or other transfer of value and make the information publicly available. CMS has provided manufacturers with the opportunity to report such information, but they are not required to do so. CMS also requested and received comments on the structure of the public website in the Final Rule. CMS is not formally issuing additional material for public comments but will continue to consider any stakeholder feedback it receives upon the launch of the site.

The Honorable Renee Ellmers

1. **Please describe in detail the proposals from CMS to reform MAC and RAC audits to ensure they are not unduly burdensome on medical equipment suppliers and providers.**

Answer: CMS is committed to reducing improper payments but must be mindful of provider and supplier burden because medical review is a resource-intensive process for both the healthcare provider and the Medicare review contractor. In many cases, the only way to identify improper payments is to request medical records from providers and suppliers and review the records along with the claim. This requires providers and suppliers to fax, mail or electronically send many pages of documentation to CMS contractors which can be time consuming and burdensome. The CMS hopes to lessen provider burden by instituting changes that will help providers and suppliers better comply with Medicare policies and documentation requests.

Recent Initiatives

- Require Medicare Administrative Contractors (MACs) to issue **"no findings" letters** at the conclusion of postpayment review. Previously, CMS only required that MACs send results letters when an overpayment was identified. Now, providers and suppliers will receive a letter at the conclusion of review even if no overpayments are identified.
  Effective Date: January 28, 2014

- Require contractors to **accept documentation** from providers via fax, CD/DVD and Electronic Submission of Medical Documentation system. Previously, CMS only required MACs to accept hard copy documentation.
  Effective Date: October 21, 2013

- Post a **review contractor directory on CMS' website** so that providers and suppliers can easily identify all Medicare review contractors in their state. This interactive map can be found at the link to the left called "Review Contractor Directory – Interactive Map".
  Effective Date: August 1, 2012

Planned Initiatives

- Require MACs to **post issues selected for focused review to their websites**. Currently, it is optional for MACs to post what they are reviewing to their websites.
  Estimated timeframe: Summer 2014

Recovery Audit Program Improvements

The CMS announced a number of changes to the Recovery Audit program in response to industry feedback. The CMS is confident that these changes will result in a more effective and efficient program, including improved accuracy, less provider and supplier burden, and more program transparency. These changes will be effective with the next Recovery Audit program contract awards.

- **More time for providers and suppliers to engage with the Recovery Auditors.** Recovery Auditors will be required to wait 30 days (to allow for a discussion period) before sending the claim to the MAC for adjustment. Today, in some cases, providers and suppliers must delay filing an appeal in order to initiate a discussion period with the RAC.

- **Improved customer service.** Recovery Auditors will be required to confirm receipt of a discussion request within three days.
- **More time before Recovery Auditors receive contingency fee if there is an appeal.** Recovery Auditors will be required to wait until the 2nd level appeal is exhausted before the CMS will pay them any contingency fee.
- **More claim diversity across a facility (e.g., inpatient, outpatient).** CMS is establishing revised additional document request limits, so that they can be diversified across claim types.
- **Number of additional document requested during Recovery Auditors review proportional to denial rates.** CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's or supplier's denial rate. Providers and suppliers with low denial rates will have lower additional document request limits while providers and suppliers with high denial rates will have higher additional document request limits.
- **Central point of contact for complaints/concerns about claim reviews.** CMS has established a Provider Relations Coordinator that can assist with Recovery Auditor review process concerns/suggestions and other contractor review process concerns/suggestions

2. **I've heard from several Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) providers in my district about CMS changing the auditing rules and penalizing a company before they were aware of the change. Will CMS set a real guideline for a grace period for changes to the audit rules before auditors can penalize company?**

Answer: CMS agrees that providers should have current information regarding payment and audit policies. Every Local Coverage Determination (LCD) has a public comment period and an effective date. In addition, policy changes that go into a CMS manual have an implementation date that is at least 30 days beyond the publication date allowing for public notice. When an audit is conducted, the payment and coverage policy that was in place at the time the service was delivered is used to make audit determinations.

3. **What specific metrics does CMS use to target entities for audits? In particular, what metrics does CMS use to target DMEPOS companies for audits?**

Answer: The MACs and the RACs analyze claims to determine provider and supplier compliance with Medicare coverage, coding, and billing rules and take appropriate corrective action when providers are found to be non-compliant. The goal of MAC and RAC administrative actions is to correct the behavior in need of change and prevent future inappropriate billing.

When improper behavior is detected, the priority for MACs is to minimize potential future losses to the Medicare Trust Funds through targeted claims review and education while using resources efficiently and treating providers, suppliers, and beneficiaries fairly.

The CMS provides instructions to it contractors through the Program Integrity Manual. The following is an excerpt from the Program Integrity Manual 3.2.1 – Setting Priorities and Targeting Reviews:

The MACs have the authority to review any claim at any time, however, the claims volume of the Medicare Program doesn't allow for review of every claim. The MACs shall target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. This requires establishing a priority setting process to assure MR focuses on areas with the greatest potential for improper payment.

The MACs shall develop a problem-focused, outcome-based MR strategy and Strategy Analysis Report (SAR) that defines what risks to the Medicare trust fund the MAC's MR programs will address and the interventions that will be implemented during the fiscal/option year as addressed in PIM chapter 7.

The MACs shall focus their edits where the services billed have significant potential to be non-covered or incorrectly coded. Medical review staff may decide to focus review on problem areas that demonstrate significant risk to the Medicare program as a result of inappropriate billing or improper payments. The MACs shall have in place a program of systematic and ongoing analysis of claims and data from Recovery Auditors and CERT, among other sources, in order to focus intervention efforts on the most significant errors.

The MACs shall initiate a targeted provider-specific prepayment review only when there is the likelihood of sustained or high level of payment error. MACs are encouraged to initiate targeted service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis.

The MACs have the discretion to select target areas because of:

- High volume of services;
- High cost;
- Dramatic change in frequency of use;
- High risk problem-prone areas; and/or,
- Recovery Auditor, CERT, Office of Inspector General (OIG) or Government Accounting Office (GAO) data demonstrating vulnerability. Probe reviews are not required when targeted areas are based on data from these entities.

In an effort to identify the claims most likely to contain improper billing, MACs are encouraged to use prepayment and postpayment screening tools or natural language coding software. MACs shall not deny a payment for a service simply because the claim fails a single screening tool criterion. Instead, the reviewer shall make an individual determination on each claim. MACs have the discretion to post the screening tools in use to their Web site or otherwise disclose to the provider community. Recovery Auditors shall use screening tools and disclose their use to the provider community consistent with the requirements in their statements of work (SOWs).

MACs and Recovery Auditors shall NOT target a provider for review solely based on the provider's preferred method of maintaining or submitting documentation. For example, a MAC or Recovery Auditor shall NOT choose a provider for review based only on the fact that the provider uses an electronic health record or responds to documentation

requests using the Electronic Submission of Medical Documentation mechanism. (More information about esMD can be found in Section 3.2.3.5

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. **Can someone with a foreign address be a Medicare provider?**

Answer: A provider or supplier must have a practice location within the United States; however, an owner may have an address outside the United States.

2. **With each recommendation made by the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) that has not been implemented, please explain the reason they have not been implemented.**

Answer:

	GAO recommendation	**Status**
1	Implement Surety Bonds	Unimplemented CMS has not scheduled for publication new regulations under this authority. CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about $1.6 million directly from surety companies, and has collected an additional $18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame.
C2	Implement providers and suppliers disclosure	Unimplemented On April 24, 2013, CMS issued a proposed rule that would implement a piece of this provision. The proposal would permit CMS to deny Medicare enrollment if the provider, supplier or current owner thereof was the owner of another provider or supplier that had a Medicare debt when the latter's enrollment was voluntarily or involuntarily terminated or revoked. CMS is considering potential provider burden in the development of additional disclosure requirements under this section.

3	Implement compliance plans	Unimplemented CMS solicited comments on compliance plans in the September 2010 proposed rule (CMS 6028-P). CMS analyzed comments and is studying issues associated with implementation of compliance plan requirements. The Office of Inspector General conducted compliance training around the country and posted video and audio podcasts of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training Initiative on its website.
4	Collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions.	Ongoing CMS has instituted an enhanced evaluation process for its contractors, but has not yet fully integrated it into the process.
5	Develop reliable schedules to incorporate all types of data into the Integrated Data Repository.	Ongoing
6	Establish deadlines for program integrity contractors to begin using One PI.	Ongoing
7	Select an approach for removing Social Security numbers from Medicare cards that best protects beneficiaries from identity theft and minimizes burdens for providers, beneficiaries and CMS.	Unimplemented CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.

	OIG Recommendation	**Status**
1	Remove Social Security Numbers from Medicare cards to help protect personally identifiable information of Medicare beneficiaries	Unimplemented CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.
2	Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns	Implemented In June 2013, CMS sent its first pharmacy risk assessment to Part D plans, and CMS has released two other assessments in December 2013 and April 2014 to seek industry comments about the methodology used to help identify high risk pharmacies.

		On May 19, 2014, CMS issued a Final Rule that permits CMS to direct access to Part D sponsors' downstream entities: This provision will provide CMS, its antifraud contractors, and other oversight agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies and other entities that contract or subcontract with Part D Sponsors to administer the Medicare prescription drug benefit. The provision will streamline CMS' and its anti-fraud contractors' investigative processes. Currently, it can take a long time for CMS' contractors who are often assisting law enforcement to obtain important documents like invoices and prescriptions directly from pharmacies, because they must work through the Part D plan sponsor to obtain this information. This provision is designed to provide more timely access to records, including for investigations of Part D fraud and abuse, and responds to recommendations from the Department of Health and Human Services (HHS) Office of Inspector General.
3	Require Part D plans to verify that prescribers have the authority to prescribe	Implemented Through rulemaking finalized in 2012, CMS required Part D sponsors to submit Prescription Drug Events (PDEs – Part D claims data) with active and valid individual prescriber National Provider Identifiers (NPIs) beginning January 1, 2013. CMS began to apply edits to any PDE without an active and valid individual NPI on May 6, 2013. On May 19, 2014, CMS issued a Final Rule that requires prescribers of Part D drugs to enroll in Medicare to help ensure CMS that Part D drugs are only prescribed by qualified individuals. CMS also finalized authority to revoke Medicare enrollment if CMS determines there is a pattern or practice of prescribing Part D drugs that is abusive, is a Drug Enforcement Administration (DEA) certificate of registration is suspended or revoked, or if the applicable licensing or

		administrative body for any state in which a physician or eligible professional practices has suspended or revoked the provider's ability to prescribe drugs.
4	Increase monitoring of Medicare claims for home health services	Implemented CMS has implemented the FPS, which runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment, including home health claims. For example, FPS is used as part of an agency focus on home health services, particularly in Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. CMS is monitoring the activity of home health agencies across Florida through the FPS to identify changes in billing patterns and the potential migration of fraud schemes to other parts of the state or Nation.
6	Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements	Unimplemented CMS is evaluating whether or not a form will help resolve the issues identified in OIG's report. However, a standardized form would eliminate some of the current flexibilities that providers are afforded. Providers are allowed to use existing information in the medical record, rather than completing a separate form, to document a face to face encounter.
7	Implement the surety bond requirement for HHAs	Unimplemented CMS has not scheduled for publication new regulations under this authority. CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about $1.6 million directly from surety companies, and has collected an additional $18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame
8	Monitor hospices that depend heavily on nursing facility residents	Implemented CMS has provided this information to the Recovery Auditors and to the Medicare

		Administrative Contractors, emphasizing the importance of this issue when prioritizing medical review strategies and other interventions.
9	Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary	Ongoing Section 3132 of the Affordable Care Act requires CMS to revise Medicare's payments system for hospice care no earlier than October 1, 2013, and allows CMS to collect additional data and information as the Secretary determines appropriate to revise payments for hospice care. In May 2014, CMS released additional analysis to inform hospice payment reforms.
10	Consider whether additional controls are needed are needed to ensure that Personal Care Services are allowed under the program rules and are provided.	CMS will conduct an analysis of personal care services' requirements and identify potential risks and vulnerabilities relating to the delivery of personal care services. CMS will gather additional data on best practices to better inform states. This information will be used to address the recommendations.
11	Take action to provide states with data suitable for identifying payments for PCS claims when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.	After the information in # 10 above is gathered and reviewed, CMS will determine the appropriate policy and evaluate the best vehicle to communicate the information.
12	Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to potential fraud and abuse.	Unimplemented CMS does not concur with this recommendation. Part D sponsors are held accountable for detecting and preventing fraud and abuse. Amending the regulation to require reporting directly to CMS itself could be considered a duplication that would require Part D sponsors to expend unnecessary additional resources and would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud. Plan sponsors report and share information related to potential fraud, waste and abuse

		(FWA) through several means which includes the FWA Work Group meetings where information is shared with CMS, law enforcement and other plan sponsors; directly contacting the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC); and by contacting 1-800-MEDICARE which will refer the case to the NBI MEDIC.
13	Establish a deadline for when complete, accurate and timely T-MSIS data will be available.	Implemented In August 2013, CMS issued a State Medicaid Director letter that established a compliance date of July 1, 2014.

3. What additional data would be valuable to help you prescreen for Medicare fraud?

Answer: CMS is currently in the process of procuring a contractor to perform fingerprint-based criminal history record checks of the Federal Bureau of Investigation databases. CMS believes this new data source will provide information about providers, suppliers and their direct or indirect owners that would permit CMS to take action when appropriate on the requirement that such individuals be free of certain federal and state felony convictions.

The Honorable Michael C. Burgess

1. Please provide the Committee with a list of the recommendations made by GAO and the OIG that have not been implemented yet.

Answer:

	OIG Recommendation	Status
1	Remove Social Security Numbers from Medicare cards to help protect personally identifiable information of Medicare beneficiaries	Unimplemented CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.
2	Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns	Implemented In June 2013, CMS sent its first pharmacy risk assessment to Part D plans, and CMS has released two other assessments in December 2013 and April 2014 to seek industry comments about the methodology used to help identify high risk pharmacies. On May 19, 2014, CMS issued a Final Rule that permits CMS to direct access to Part D sponsors' downstream entities: This provision will provide CMS, its antifraud contractors, and other oversight agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies and other entities that contract or subcontract with Part D Sponsors to administer the Medicare prescription drug benefit. The provision will streamline CMS' and its anti-fraud contractors' investigative processes. Currently, it can take a long time for CMS' contractors who are often assisting law enforcement to obtain important documents like invoices and prescriptions directly from pharmacies, because they must work through the Part D plan sponsor to obtain this information. This provision is designed to provide more timely access to records, including for investigations of Part D fraud and abuse, and responds to recommendations from the Department of Health and Human Services (HHS) Office of Inspector General.
3	Require Part D plans to verify	Implemented

	that prescribers have the authority to prescribe	Through rulemaking finalized in 2012, CMS required Part D sponsors to submit Prescription Drug Events (PDEs – Part D claims data) with active and valid individual prescriber National Provider Identifiers (NPIs) beginning January 1, 2013. CMS began to apply edits to any PDE without an active and valid individual NPI on May 6, 2013. On May 19, 2014, CMS issued a Final Rule that requires prescribers of Part D drugs to enroll in Medicare to help ensure CMS that Part D drugs are only prescribed by qualified individuals. CMS also finalized authority to revoke Medicare enrollment if CMS determines there is a pattern or practice of prescribing Part D drugs that is abusive, is a Drug Enforcement Administration certificate of registration is suspended or revoked, or if the applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the provider's ability to prescribe drugs.
4	Increase monitoring of Medicare claims for home health services	Implemented CMS has implemented the FPS, which runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment, including home health claims. For example, FPS is used as part of an agency focus on home health services, particularly in Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. CMS is monitoring the activity of home health agencies across Florida through the FPS to identify changes in billing patterns and the potential migration of fraud schemes to other parts of the state or Nation.
6	Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements	Unimplemented CMS is evaluating whether or not a form will help resolve the issues identified in OIG's report. However, a standardized form would eliminate some of the current flexibilities that

		providers are afforded. Providers are allowed to use existing information in the medical record, rather than completing a separate form, to document a face to face encounter.
7	Implement the surety bond requirement for HHAs	Unimplemented CMS has not scheduled for publication new regulations under this authority. CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about $1.6 million directly from surety companies, and has collected an additional $18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame
8	Monitor hospices that depend heavily on nursing facility residents	Implemented CMS has provided this information to the RACs and MACs, emphasizing the importance of this issue when prioritizing medical review strategies and other interventions.
9	Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary	Ongoing Section 3132 of the Affordable Care Act requires CMS to revise Medicare's payments system for hospice care no earlier than October 1, 2013, and allows CMS to collect additional data and information as the Secretary determines appropriate to revise payments for hospice care. In May 2014, CMS released additional analysis to inform hospice payment reforms.
10	Consider whether additional controls are needed are needed to ensure that Personal Care Services are allowed under the program rules and are provided.	CMS will conduct an analysis of personal care services' requirements and identify potential risks and vulnerabilities relating to the delivery of personal care services. CMS will gather additional data on best practices to better inform states. This information will be used to address the recommendations.
11	Take action to provide states with data suitable for identifying payments for PCS claims when beneficiaries are receiving	After the information in #10 above is gathered and reviewed, CMS will determine the appropriate policy and evaluate the best vehicle to communicate the information.

	institutional care paid for by Medicare or Medicaid.	
12	Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to potential fraud and abuse.	Unimplemented CMS does not concur with this recommendation. Part D sponsors are held accountable for detecting and preventing fraud and abuse. Amending the regulation to require reporting directly to CMS itself could be considered a duplication that would require Part D sponsors to expend unnecessary additional resources and would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud. Plan sponsors report and share information related to potential fraud, waste and abuse (FWA) through several means which includes the FWA Work Group meetings where information is shared with CMS, law enforcement and other plan sponsors; directly contacting the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC); and by contacting 1-800-MEDICARE which will refer the case to the NBI MEDIC.
13	Establish a deadline for when complete, accurate and timely T-MSIS data will be available.	Implemented In August 2013, CMS issued a State Medicaid Director letter that established a compliance date of July 1, 2014.

	GAO recommendation	**Status**
1	Implement Surety Bonds	Unimplemented CMS has not scheduled for publication new regulations under this authority. CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about $1.6 million directly from surety companies, and has collected an additional $18.5 million directly from suppliers immediately after their debts were referred to their respective

		sureties for payment for the same time frame.
2	Implement providers and suppliers disclosure	Unimplemented On April 24, 2013, CMS issued a proposed rule that would implement a piece of this provision. The proposal would permit CMS to deny Medicare enrollment if the provider, supplier or current owner thereof was the owner of another provider or supplier that had a Medicare debt when the latter's enrollment was voluntarily or involuntarily terminated or revoked. CMS is considering potential provider burden in the development of additional disclosure requirements under this section.
3	Implement compliance plans	Unimplemented CMS solicited comments on compliance plans in the September 2010 proposed rule (CMS 6028-P). CMS analyzed comments and is studying issues associated with implementation of compliance plan requirements. HHS OIG conducted compliance training around the country and posted video and audio podcasts of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training Initiative on its website.
4	Collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions.	Ongoing CMS has instituted an enhanced evaluation process for its contractors, but has not yet fully integrated it into the process.
5	Develop reliable schedules to incorporate all types of data into the Integrated Data Repository.	Ongoing
6	Establish deadlines for program integrity contractors to begin using One PI.	Ongoing
7	Select an approach for removing Social Security numbers from Medicare cards that best protects beneficiaries from identity theft and minimizes burdens for providers, beneficiaries and CMS.	Unimplemented CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.

The Honorable Renee Ellmers

1. **You suggested CMS is making changes in the next RAC audit time period so that providers who have a low denial rate are rewarded. What is the percentage of providers who are rewarded, if they have a low denial rate?**

Answer: CMS plans to require RACs to adjust the Additional Documentation Request limits in accordance with a provider's denial rate, under the new Recovery Audit contracts. Providers with low denial rates will have lower additional document request limits while providers with high denial rates will have higher additional document request limits. More information will be available when the next contract procurement is finalized.

The Honorable Diana DeGette

1. **How much will CMS spend this year on Medicare and Medicaid program integrity efforts?**

Answer: CMS has available funding for program integrity in FY 2014 of approximately $1.4 billion after sequestration, including funds from the following sources: Healthcare Fraud and Abuse Control (HCFAC) accounts, user fees for Medicare provider enrollment and oversight, and the Medicaid Integrity Program under section 1936 of the Social Security Act. Of this amount, approximately $176.6 million is for Medicaid program integrity.

2. **Please explain your plans for the money if Congress appropriates the requested funding for your agency.**

Answer: The President's FY 2015 Budget proposes to build on recent progress by increasing support for the HCFAC program through both mandatory and discretionary funding streams. The HCFAC investment supports efforts to reduce the Medicare FFS improper payment rate and initiatives of the joint HHS-DOJ HEAT task force, including Strike Force teams in cities where intelligence and data analysis indicate high levels of fraud, and the HFPP between the Federal Government, private insurers, and other stakeholders. CMS will also make further investments in innovative prevention initiatives, such as the FPS that analyzes all Medicare FFS claims using sophisticated algorithms to identify suspicious behavior. In FY 2015 and beyond, CMS will continuously refine these technologies to better combat fraud, waste, and abuse in Medicare, Medicaid, and CHIP. Finally, these funds will support more rigorous data analysis and an increased focus on civil fraud, such as off-label marketing and pharmaceutical fraud. A complete breakdown of allocations for the FY 2015 HCFAC Budget proposal is attached.

FY 2015 CMS HCFAC Funding Request
(Dollars in Thousands)

Project or Activity	FY 2015 Base Request	FY 2015 Additional Funding	FY 2015 Total Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D			
Medicare Drug Integrity Contractors (MEDICs)	$25,300	$0	$25,300
Part C & D Contract/Plan Oversight	$28,314	$0	$28,314
Monitoring, Performance Assessment, and Surveillance	$55,117	$0	$55,117
Program Audit	$39,283	$0	$39,283
Compliance and Enforcement	$21,377	$0	$21,377
Total	**$169,391**	**$0**	**$169,391**
II. Program Integrity Staffing & Support			
Field Offices/Rapid Response/and Oversight Staffing	$10,726	$23,473	$34,199
Total	**$10,726**	**$23,473**	**$34,199**
III. Program Integrity Special Initiatives			
Automated Provider Screening	$3,519	$6,481	$10,000
1-800 Medicare Integration	$0	$3,200	$3,200
Case Management System	$0	$5,000	$5,000
Technology and Strategic Decision Support	$0	$2,000	$2,000
Beneficiary Fraud Outreach	$0	$4,000	$4,000
Joint Hospice Project	$0	$2,000	$2,000
Southern California Rapid Response	$0	$2,000	$2,000
Total	**$3,519**	**$24,681**	**$28,200**
IV. Prevent Excessive Payments			
Fraud Prevention System	$24,000	$0	$24,000
Fraud System Enhancements	$0	$2,000	$2,000
Command Center	$0	$2,000	$2,000
Benefits Integrity	$0	$29,880	$29,880
Medical Review	$0	$17,250	$17,250
Total	**$24,000**	**$51,130**	**$75,130**
V. Program Integrity Oversight Efforts			
Overpayment/Payment Suspension	$0	$5,000	$5,000
Compromised Numbers Checklist	$0	$1,400	$1,400
National Supplier Clearinghouse	$0	$27,822	$27,822
One PI Data Analysis	$0	$18,869	$18,869
HEAT Support / Strike Force	$0	$2,000	$2,000
Appeals Initiatives	$0	$4,654	$4,654
Healthcare Fraud Prevention Partnership	$0	$29,500	$29,500
Probable Fraud Study Database & Analysis	$0	$3,500	$3,500
Total	**$0**	**$92,745**	**$92,745**

FY 2015 CMS HCFAC Funding Request
(Dollars in Thousands)

Project or Activity	FY 2015 Base Request	FY 2015 Additional Funding	FY 2015 Total Request
VI. Medicaid Program Integrity Initiatives			
Payment Error Rate Measurement (PERM)	$21,000	$0	$21,000
Correct Coding Initiative	$0	$1,500	$1,500
State Readiness, Enrollment and Eligibility	$0	$4,000	$4,000
Medicaid and CHIP Business Information Solutions (MACBIS)	$0	$7,236	$7,236
Physician Transparency	$4,000	$0	$4,000
Healthcare Fraud Prevention Partnership	$0	$4,500	$4,500
IT Shared Services	$4,708	$4,730	$9,438
Total	**$29,708**	**$21,966**	**$51,674**
VII. Private Insurance Program Integrity			
Private Insurance PI	$0	$25,000	$25,000
Total	**$0**	**$25,000**	**$25,000**
HCFAC Summary			
Total Medicare Integrity	**$207,636**	**$192,029**	**$399,665**
Total Medicaid Integrity	**$29,708**	**$21,966**	**$51,674**
Total Private Insurance Integrity	**$0**	**$25,000**	**$25,000**
Total CMS Funding Request	**$237,344**	**$238,995**	**$476,339**

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

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July 18, 2014

Mr. Gary Cantrell
Deputy Inspector General for Investigations
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Cantrell:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, June 25, 2014, to testify at the hearing entitled "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, August 1, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Committee on Energy & Commerce
Subcommittee on Oversight and Investigations
"Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"
6/25/14

HHS OIG QFR Responses – submitted 8/1/14

The Honorable Tim Murphy

1. CMS says the Fraud Prevention System (FPS) "prevented more than $210 million in improper Medicare fee-for-service payments, double the previous year." But according to the OIG's comments in the report, OIG only certified $54.2 million of actual savings in the Medicare program. Can you please explain why CMS is claiming higher numbers than OIG says may be verifiable?

Answer:

Both the identified amount of $210.7 million and the adjusted savings amount of $54.2 million are verifiable. The $210.7 million represents how much the FPS identified through administrative actions. However, the $210.7 million does not represent funds actually returned to, or prevented from leaving, the Medicare Trust Fund. CMS determined its FPS estimate on the basis of how much the FPS identified regardless of whether that full amount will be returned to, or prevented from leaving, the Trust fund. However, our adjusted savings amount provides a more accurate estimate of the dollars that the Department of Health and Human Services (the Department) has already returned, or is likely to return in the future, from the identified or unadjusted savings.

For example, the FPS may have targeted providers for investigations that resulted in the Zone Program Integrity Contractors and Program Safeguard Contractors (contractors) calculating overpayments of $10 million. However, we would only certify the portion of that overpayment that can reasonably be expected to be recovered based on historical data for the collection of overpayments when identified by the contractors. We define "certify" to mean a determination that the Department reported actual and projected savings and its return on investment that were reasonably estimated.

2. At the end of the OIG's report on the FPS, there is some extended discussion between CMS and OIG regarding two issues: (1) contractors being given written instructions to determine when savings from an administrative action should be attributed to the FPS, and (2) requiring contractors to maintain documentation supporting the claim that an FPS lead contributes to an administrative action. Can you briefly outline your recommendations, CMS's perspective, and what you think should happen now? OAS

Answer:

Summary of Recommendations

We recommended that the Department (1) provide its contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS and (2) require contractors to maintain documentation to support how the FPS lead contributes to an administrative action. That is, we wanted CMS to issue written instructions to the contractors clearly delineating how the contractors should document the contribution of the FPS lead to the investigation and achievement of the administrative action.

CMS' Perspective and OIG's Position

Despite the extended discussion in the comments section of our report, CMS concurred with both of our recommendations in its comments and stated that it "will issue a Technical Direction Letter" to the contractors that would provide "written instruction on how to determine whether an investigation initiated a new investigation or corroborated, augmented, and/or expedited an existing investigation." CMS also stated it "will issue a Technical Direction Letter" to the contractors that would provide "written instructions on maintaining documentation when an FPS lead initiated a new investigation or corroborated, augmented, and/or expedited an existing investigation." CMS, however, also mentioned in its comments (1) the significance of identified savings versus adjusted savings and (2) the $39 million that we did not certify.

Identified Savings Versus Adjusted Savings

CMS' Perspective

According to CMS' second year report to Congress, the adjusted savings number is an attempt to estimate the dollars that CMS has or is likely to return to the Treasury from the larger category of identified savings. CMS also reports that the concept of adjusted savings is important for a financial audit but is of limited utility for determining the overall impact of the FPS and the purpose of the FPS which is to detect potential fraud. Thus, CMS believes that identified savings is a more meaningful measure of the impact of the FPS.

OIG's Position

The Small Business Jobs Act of 2010 requires that OIG certify actual and projected savings with respect to improper payments recovered and avoided. In this regard, the OIG reported that identified savings does not always result in the collection of overpayments or the avoidance of payments. In order to estimate how much of the identified savings would actually be collected or avoided, CMS applied its adjustment factors to the identified savings to determine the adjusted savings. Thus, the adjusted savings is a more accurate measure of the savings and return on investment for the Department's use of the FPS. As stated on page 8 of our report, "Identified savings does not represent a true return on investment because only a portion of those savings are returned to, or prevented from leaving, the Medicare Trust Funds."

The $39 Million That OIG Did Not Certify

CMS' Perspective

CMS asserts that outcomes resulting from existing investigations that were corroborated, augmented, and/or expedited by the FPS should be counted in the full value of savings and therefore, the OIG should have recognized and certified the $39 million in question.

OIG's Position

For our second year report, we did not recognize the $39 million as identified savings because, although there may have been an FPS lead related to the investigation, the contractors reported to us that the lead made no contribution to achievement of the administrative action. If the contractors demonstrated and documented that the FPS made an actual contribution to the investigation and the achievement of the administrative action then we would have attributed 100 percent of these savings to the FPS.

The OIG understands and agrees with CMS that investigations are fluid and dynamic and that investigators need to work a case using all available information. If investigators are required to allocate the results of an investigation back to each piece of information in decision making, it would be extremely time consuming, completely subjective, and highly disruptive for the investigators. Therefore, we counted those administrative actions in the full value of identified savings.

However, if the FPS lead is said to "corroborate, augment, and/or expedite" an investigation, but the contractor could not demonstrate or document that the FPS lead actually contributed to the investigation or the contractor stated that the FPS lead had no impact on achieving the administrative action, we did not attribute these savings to the FPS.

NEXT STEPS

We have already begun contacting the contractors to discuss any written instructions that CMS provided to them to address our recommendations and how the contractors are documenting the contribution of the FPS in achieving any reportable savings.

For the third-year report, we will separately report the savings for which the FPS lead was able to "corroborate, augment, and/or expedite" an investigation if the investigators can document a contribution from the FPS lead in achieving the savings. These savings will be combined with savings from investigations initiated by FPS in calculating the certified ROI. However, OIG will continue to not recognize as identified savings administrative actions that result from an FPS lead that is said to corroborate, augment, and/or expedite an investigation if the contractors cannot demonstrate and document that the FPS made an actual contribution to achieving the administrative actions.

3. Some reports have noted that CMS has not published a proposed rule that would permit more disclosure of prior actions against providers and suppliers that were enrolling or revalidating their Medicare enrollment. How would such disclosure help fight fraud? For instance, would contractors that CMS currently works with- including Medicare Advantage and drug plan sponsors- be better able to identify fraudulent providers up front if they had access to such information?

Revised Question Received from Committee:

GAO has noted that CMS has not published a proposed rule that would permit more disclosure of prior actions against providers and suppliers that were enrolling or revalidating their Medicare enrollment (see Medicare: Further Action Could Improve Improper Payment Prevention and Recoupment Efforts, GAO-14-619T). These disclosures would include whether or not the providers or suppliers had been subject to previous federal health care program suspensions. That's because § 6401(a) of the ACA requires providers and suppliers to disclose at initial enrollment or enrollment revalidation any current or previous affiliations with other providers or suppliers that have uncollected debt; has been subject to a federal health care program payment suspension; has been excluded from Medicare, Medicaid, or CHIP; or has had its billing privileges revoked. In OIG's opinion, would CMS's publishing a final rule and using (and allowing their contractors to use) the disclosure of prior actions against providers and suppliers be a useful step to reduce program vulnerabilities and fraud? For instance, would contractors that CMS currently works with—including Medicare Advantage and drug plan sponsors—be better positioned to identify improper payments or potentially fraudulent providers sooner if they had access to such information?

Answer:

It's possible, but there would be a number of factors to consider, such as the reliability of disclosures (e.g., entities intent on committing fraud might not adhere to a self-disclosure requirement and could enroll under an alias or name not associated with prior adverse actions) and how contractors and plans currently identify fraud. OIG has work underway, "Review of Enhanced Enrollment Screening Process for Medicare Providers," that might further inform this discussion, and would be happy to brief the Committee upon completion of the review.

4. The Centers for Medicare & Medicaid Services has agreed to postpone awarding the new round of Recovery Auditor Contractor (RAC) contracts until at least Aug. 15 because of pending litigation. This delay comes after numerous administrative changes and delays to the statutorily mandated program. Given the RACs record of recovering hundreds of millions, even billions, of dollars for the Medicare Trust Fund, does GAO have any concerns regarding the impact further administrative or legal delays may have on the effectiveness of the recoveries for the Medicare Trust Fund from this statutorily mandated program?

Answer:
OIG does not have a basis on which to opine on this question.

5. Do you believe the Medicare program would be more protected than it currently is if HHS OIG were given the authority to exclude a supplier/provider from federal health care programs once that individual has been convicted, instead of waiting for sentencing?

Answer:

By statute, the OIG has the authority to exclude an individual or entity from participation in federal health care programs at the time of conviction. At section 1128(i) of the Social Security Act defines a conviction for exclusion purposes as:
(i) Convicted Defined.—For purposes of subsections (a) and (b), an individual or entity is considered to have been "convicted" of a criminal offense—
(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;
(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;
(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or
(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

Based on this definition, a subject could be excluded at the point a court accepts a plea agreement, accepts a verdict, or finds guilt. Historically, the OIG has excluded after sentencing as a matter of policy for two reasons:

- Many of the factors used to determine a reasonable period of exclusion are established only after sentencing. The majority of exclusion actions are derivative actions based on findings of a court or a state entity. The most significant factors to be considered in determining a reasonable period of exclusion, as listed in the OIG's regulations, are based on facts discovered at sentencing. Aggravating factors such as loss to the programs and incarceration, as well as the mitigating factors of mental incapacity and cooperation, factors common to most conviction-based exclusions, are more often than not determined only at the time of sentencing. These are important factors used in the determination of an appropriate period of exclusion.

- Documentation of action by various courts has, in many cases, not clearly indicated that a plea or verdict has been accepted by the court. For an exclusion action to be legally sufficient, the OIG must obtain documentation that clearly shows that the court accepted a plea or verdict or found the subject guilty. This documentation is usually not available, and sometimes not created, until sentencing.

6. Do you think it makes sense, from a program integrity perspective, for Congress to give HHS OIG or CMS more latitude to suspend, terminate, or otherwise exclude a supplier/provider from federal health care programs if that individual has been convicted of a felony?

Answer:

CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges based on conviction of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. The examples set forth

in the relevant regulations, 42 CFR 424.535(a)(3), could provide a useful analogue in developing a proposal to expand OIG's exclusion authorities.

However, exclusion has a very broad effect, and requiring that the conviction or underlying conduct be tied to the delivery of a health care item or service could be viewed as a reasonable conscription of the exclusion authority. It also important to note that expansion of the exclusion statute in this way might not necessarily afford more protection to the programs, and could result in OIG needing to expend significant additional resources focusing on non-health care-related crimes and referrals.

OIG would welcome the opportunity to further discuss this and other proposals that would enhance OIG's enforcement authorities. Via separate technical assistance documents, OIG has provided recommendations to the Committee for improvements to the Civil Monetary Penalty Law and various exclusions authorities.

7. What do you believe are the top five vulnerabilities with regard to the integrity of Medicaid payments?

Answer:

OIG has identified Protecting the Integrity of an Expanding Medicaid Program as a Top Management Challenge for the Department.[1] One of the most significant vulnerabilities relating to ensuring the integrity of Medicaid payments is the lack of timely, accurate, complete national Medicaid data.[2] We have also uncovered significant problems when States game the system to artificially inflate their share of Federal matching funds and CMS does not act quickly to stop it. Additional areas of vulnerability include personal care services, Medicaid drug pricing, and Medicaid managed care. A fuller discussion of priority recommendations and related program vulnerabilities can be found in OIG's *Compendium of Priority Recommendations*.[3]

The Honorable Michael C. Burgess

1. What recommendations has the OIG made to CMS relating to improvements in the screening of providers or fund recipients that have not been adopted? Which ones have not been adopted? Has CMS given reasons for not adopting certain recommendations? What are those reasons?

Answer:

Report: *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600

[1] *2013 Top Management & Performance Challenges*, available at http://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge04.asp.
[2] *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System*, available at http://oig.hhs.gov/oei/reports/oei-05-12-00610.asp.
[3] Available at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

Recommendation:

CMS Should Strengthen the MEDIC's Monitoring of Pharmacies and Ability To Identify Pharmacies for Further Review

CMS Response:

CMS stated that it and the MEDIC would continue to refine data analysis on emerging trends and best available data. It also stated that it would consider the methodology used by OIG and explore approaches that could improve that methodology. In addition, CMS stated that the use of the pharmacy risk scores that the MEDIC is developing would strengthen the MEDIC's monitoring of pharmacies and ability to identify pharmacies for further review. Lastly, CMS stated that it reviews MEDIC data analysis at a weekly data analysis meeting to ensure the MEDIC monitors fraud at the pharmacy level. We believe that CMS's completed and planned actions would address the recommendation, when fully implemented. However, more documentation is needed. In its notification of final action, we request that CMS provide documentation explaining the analysis the MEDIC is conducting and the steps CMS has taken to strengthen this analysis, such as the weekly meeting.

Recommendation:

CMS Should Develop Risk Scores for Pharmacies

CMS Response:

CMS stated that a potential fraud risk assessment for pharmacies was completed on April 5, 2013. CMS also stated that it sent a Health Plan Management System (HPMS) memo to sponsors on June 21, 2013 that included a list of high risk pharmacies to assist plan sponsors in targeting pharmacies for audits and further analysis. The HPMS memo further stated that CMS plans to release a list of high risk pharmacies on a quarterly basis. We are supportive of the steps that CMS has taken to implement this recommendation. We believe this recommendation will be fully implemented when CMS begins to release the lists of high risk pharmacies on a routine or quarterly basis. We recommend that in its next release, CMS provide information to sponsors about why each pharmacy was identified as high risk. In its notification of final action, we request that CMS provide documentation that it is routinely providing these lists to sponsors.

Report: *Prescribers with Questionable Patterns in Medicare Part D*, OEI-02-09-00603

Recommendation:

CMS should instruct the MEDIC to expand its analysis of prescribers.

CMS Response:

CMS stated that it works continuously with the MEDIC to monitor prescribers and that the MEDIC has completed data analysis projects that make connections among the prescribers, pharmacies and beneficiaries. For example, the MEDIC completed a Health Care Fraud Prevention and Enforcement Action Team (HEAT) analysis. CMS stated that it will continue to work with the MEDIC to expand its analysis of prescribers. Additionally, CMS has increased its monitoring of prescribers through the Part D Recovery Audit Contractor. OIG does not believe that actions CMS described above fully address this recommendation. However, at the Medicare Parts C & D Fraud Work Group Webinar on January 9, 2014, CMS and the MEDIC announced that they are developing prescriber risk scores that take into account the prescriber's specialty and that they will provide lists of high risk prescribers to sponsors on an ongoing basis. We believe these actions would address the recommendation, when fully implemented. In its Notification of Final Action, we request that CMS provide documentation showing that the Part D sponsors have received a list of high risk prescribers.

Recommendation:

CMS should provide sponsors with additional guidance on monitoring prescribing patterns.

CMS Response:

CMS stated it conducted a virtual Fraud Waste and Abuse Work Group on June 18, 2013 for Part D plan sponsors in which drug overutilization was one topic on the agenda. CMS also stated that it will provide general guidance "red flags" to sponsors concerning aberrant and abusive prescribing patterns that it detects. In addition, CMS stated that it issued guidance to sponsors reiterating that their opioid overutilization programs are expected to include policies and procedures for referrals to appropriate agencies. CMS believes it is too early to implement additional guidance. We believe the actions described above do not fully address the recommendation. To fully implement this recommendation, CMS should issue additional guidance to sponsors about how to effectively monitor prescribers. For example, guidance on how sponsors should monitor the prescribers that CMS identifies as having a high risk score could implement this recommendation.

Report: *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608

Recommendation:

CMS should increase the MEDIC's monitoring of prescribers.

CMS Response:

CMS stated that the MEDIC is conducting proactive analysis to identify prescribers who do not have the authority to prescribe drugs and that the MEDIC will continue to monitor prescribers. In addition, CMS stated that it has increased its monitoring of prescribers through the Part D Recovery Audit Contractor (RAC). Further, CMS noted that the MEDIC completed an analysis of deceased prescribers and the RAC completed an analysis of excluded providers. We do not believe that the analyses of deceased and excluded

prescribers fully implement this recommendation. In its notification of final action, CMS should provide documentation of the results of the MEDIC's proactive analysis to identify prescribers who do not have authority to prescribe drugs.

Report: *Surety Bonds Remain an Underutilized Tool to Protect Medicare from Supplier Overpayments*, OEI-03-11-00350

Recommendation:

Improve oversight of supplier data to ensure accurate and consistent information.

CMS Response:

CMS implemented enhancements to the Provider Enrollment, Chain and Ownership System (PECOS) in January 2013 and July 2013. These enhancements include validation checks for dates and surety bond amounts entered in PECOS. In addition, contractors will now collect surety bond information at the associate and enrollment level. CMS did not concur with part of OIG's recommendation that it review all surety bond data within PECOS to identify other discrepancies or errors resulting from the transition from the Provider Information Management System to PECOS. CMS indicated that reviewing all PECOS fields was unnecessary because it and the National Supplier Clearinghouse conducted a thorough review of all currently enrolled DMEPOS suppliers and have verified that each entity, not otherwise exempt, is appropriately covered by a valid surety bond. OIG believes CMS's actions partially implement this recommendation. CMS's actions to enhance the PECOS system validation checks address part of this recommendation. However, because CMS does not plan to review all surety bond data within PECOS to identify discrepancies, as recommended, OIG will continue to consider this recommendation unimplemented. While OIG acknowledges CMS's efforts to ensure that DMEPOS suppliers are covered by valid surety bonds, this effort does not mean that the data discrepancies and errors we observed in the PECOS system have been addressed. OIG found numerous errors in PECOS as a result of the data system transition and continues to recommend that CMS conduct a quality check of the PECOS data to ensure that it is accurate, consistent, and accessible. OIG would consider this recommendation implemented when CMS provides additional documentation showing that quality checks of the PECOS data have been performed.

Report: *Vulnerabilities in CMS's and Contractors' Activities To Detect and Deter Fraud in Community Mental Health Centers*, OEI-04-11-00101

Recommendation:

CMS should develop a system to track revocation recommendations and improve revocation communication with contractors.

CMS Response:

In its final management decision, CMS stated that it established a set of guidelines for Zone Program Integrity Contractors (ZPICs) and Medicare Administrative Contractors (MACs) to ensure that revocation recommendations are addressed in a timely manner. These require ZPICs and MACs to submit revocation requests to a designated CMS revocation email mailbox. Additionally, CMS stated that it has developed and implemented a tracking system used by the revocation team which delineates revocation-specific duties, dates, and statuses. OIG believes that CMS's guidelines and tracking system are positive steps towards implementing this recommendation. For OIG to consider this recommendation fully implemented, we request that CMS provide documentation of ZPIC and MAC responses to the guidelines in its notification of final action. We also request that CMS provide further information about the revocation tracking system, such as standard operating procedures, and documentation of the functionality of the revocation email mailbox and the revocation tracking system.

Report: *Medicare Inappropriately Paid for Drugs Ordered By Individuals Without Prescribing Authority*, OEI-05-09-00608

Recommendation:

CMS should increase the MEDIC's monitoring of prescribers.

CMS Response:

CMS stated that the MEDIC is conducting proactive analysis to identify prescribers who do not have the authority to prescribe drugs and that the MEDIC will continue to monitor prescribers. In addition, CMS stated that it has increased its monitoring of prescribers through the Part D Recovery Audit Contractor (RAC). Further, CMS noted that the MEDIC completed an analysis of deceased prescribers and the RAC completed an analysis of excluded providers. We do not believe that the analyses of deceased and excluded prescribers fully implement this recommendation. In its notification of final action, CMS should provide documentation of the results of the MEDIC's proactive analysis to identify prescribers who do not have authority to prescribe drugs.

Recommendation:

CMS should ensure that Medicare does not pay for prescriptions from individuals without prescribing authority.

CMS Response:

CMS stated that current Prescription Drug Event (PDE) guidance provides Part D sponsors with a process to delete PDEs that are fraudulent. PDEs from prescribers confirmed by the MEDIC as not having prescribing authority would be communicated back to sponsors who would then delete the PDEs and implement point of sale edits to reject claims from these prescribers. CMS also cited a memorandum to sponsors entitled, Clarification of Recovery of Part D Payment for Pain Medications for Beneficiaries Enrolled in Hospice. We do not believe that the memorandum related to hospices addresses this recommendation. To fully implement this recommendation, CMS should issue guidance that requires sponsors to: 1)

review PDE records to verify that the prescriber is associated with a type of prescriber that has the authority to prescribe and 2) to submit adjustments and deletions when appropriate. CMS should also monitor sponsors' performance to make sure they are appropriately adjusting the PDE records.

Report: *Program Integrity Problems with Newly Enrolled Medicare Equipment Suppliers*, OEI-06-09-00230

Recommendation:

Apply investigative techniques and tools to identify any owners or managers of DMEPOS suppliers who are not reported on supplier applications as required.

CMS Response:

CMS stated it will implement measures to identify individuals affiliated with companies but not reported on enrollment documents. CMS will have its new screening contractor alert Medicare Administrative Contractors (MAC), including the National Supplier Clearinghouse (NSC) MAC, when individuals are identified through external referential data sources as having a managerial or ownership association with a supplier but not reported in the enrollment documents. OIG believes that CMS's planned actions, when fully implemented, will be sufficient to address this recommendation. In its notification of final action to the OIG, we request that CMS provide documentation of the new contractor actually conducting activities to identify owners and managers, the nature and results of those activities, transmissions of owner/manager information to the NSC-MAC, and enforcement/corrective actions, when appropriate.

Recommendation:

Take appropriate action regarding DMEPOS suppliers identified in the report that omit information from their applications.

CMS Response:

CMS stated that it was researching the list of 27 suppliers and would take action, if appropriate. As of June 11, 2012, CMS had determined 17 of the 27 suppliers were no longer in an approved status and 1 supplier had disclosed the missing information. For the remaining nine suppliers, CMS indicated that the NSC would either start the revalidation process or develop the missing information and take further administrative action as deemed appropriate. CMS indicated that it will also continue to refer to law enforcement for action at their discretion any additional individuals and suppliers identified as having inappropriately omitted required information on the enrollment application. OIG believes that the planned actions CMS described in its 2012 final management decision, when fully completed, would implement OIG's recommendation. In its notification of final action to the OIG, we request CMS provide evidence concerning the status of the remaining nine suppliers.

Report: *Inaccurate, Incomplete, and Inconsistent Provider Enumeration and Medicare Enrollment Data*, OEI-07-09-00440

Recommendation:

Require MACs to implement program integrity safeguards for Medicare provider enrollment as established in the PIM.

CMS Response:

CMS states that MACs must adhere to the processing guidelines established in the PIM. However, MACs reported to OIG that supplemental guidance waived their responsibility to verify data required by the PIM. It is not clear to OIG that MACs understand that they must verify all enrollment application data. CMS should remind MACs that they must verify all enrollment application data, and rescind supplemental guidance issued to expedite the processing of enrollment applications by verifying only select application data. In its notification of final action, CMS should provide evidence that they have informed MACs of their duty to verify all enrollment application data as required by the PIM.

Recommendation:

Require more verification of NPPES enumeration and PECOS enrollment data.

CMS Response:

CMS states that they are more rapidly deactivating National Provider Identifiers (NPIs) for deceased providers, and working to rapidly deactivate NPIs for invalid practice locations. OIG does not believe that either of these actions demonstrates more verification of NPPES or PECOS data at the time of application. CMS could use the new PECOS automated provider-screening tool to verify provider application data in NPPES, monitor NPPES applications by geographic area to detect potential fraud, and/or determine whether providers' locations are legitimate at the time they enroll in PECOS. In its notification of final action, CMS should provide documentation of additional verification of NPPES and PECOS application data.

Recommendation:

Detect and correct inaccurate and incomplete provider enumeration and enrollment data for new and established records.
CMS Response:

CMS states that changes to PECOS have increased the number of applications submitted online, and that recent system enhancements will decrease inaccurate and incomplete data. CMS plans to match enrollment data against public and private databases to minimize inaccurate and incomplete data, and encourage providers to update their records through an ongoing revalidation effort. We believe that CMS's planned actions, when completed subject to the clarifications below, will implement this recommendation. In its notification of final action, CMS should provide evidence of the success of the measures implemented to

decrease inaccurate and incomplete data. CMS should also provide documentation of the planned process to match enrollment data against various databases.

Attachment 2-Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. What additional data would be valuable to help you prescreen for Medicare fraud?

The Honorable Michael C. Burgess

1. Do you have the ability to get a query of the National Practitioner Data Bank

Answer:

Gaining or modifying access to two data sources would assist OIG in pursuing exclusion actions. Gaining access to the National Crime Information Center for assistance in exclusion investigations, and modifying access to the National Practitioner Data Bank for investigation support would enhance OIG's exclusion operations.

National Crime Information Center (NCIC)

In April 2012, the Federal Bureau of Investigation terminated access to the National Crime Information Center (NCIC) for OIG's Exclusion Program. This decision was based upon DOJ/CJIS policy that does not allow an agency to run criminal history queries except for the express purpose of the "administration of Criminal Justice." As such, administrative processes, such as the investigation of exclusion matters, were deemed a disallowed purpose to run NCIC queries. However, there is legislative precedent for administrative access. For example, section 6201 of the Affordable Care Act authorized the use of background checks on prospective direct patient access employees – an administrative action related to the provision of health care.

Criminal history information is used in support of the exclusion process in a number of areas:

1. Determination of previous convictions related to health care that could form the basis for an exclusion period enhancement under 1128(c)(3)(g) of the Social Security Act.
2. Support for the aggravating factors found at 42 CFR 1001.102(b):
    i. (6) The convicted individual or entity has a prior criminal, civil or administrative sanction record;

ii. (8) The individual or entity has previously been convicted of a criminal offense involving the same or similar circumstances; and
iii. (9) Whether the individual or entity was convicted of other offenses besides those which formed the basis for the exclusion, or has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for imposition of the exclusion.

National Practitioner's Data Bank (NPDB)

Initially, OIG used the Health Integrity and Protection Data Bank (HIPDB) as a source of information in support of exclusion actions. HIPDB contained final adverse actions taken against health care providers, suppliers, and practitioners such as civil judgments, criminal convictions, licensing actions, exclusions from Federal and State health care programs and other adjudicated actions. The OIG maintained access to HIPDB at no cost to the agency. HIPDB information was available to certain federal and state agencies (mostly law enforcement agencies) and health plans. In May 2013, under Section 6403 of the Affordable Care Act, the HIPDB became part of the NPDB in an effort to eliminate a duplication of information in both the HIPDB and NPDB. The information OIG accessed in HIPDB is now accessed (at a fee) from NPDB.

The NPDB is a confidential information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the U.S. The NPDB is administered by the Health Resources and Services Administration within the Department of Health and Human Services. Per the NPDB's website:

> The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of the professional credentials of health care practitioners, health care entities, providers, and suppliers; the information from the Data Bank should be used in conjunction with, not in replacement of, information from other sources.

Prior to the consolidation of NPDB and HIPDB, NPDB contained only medical malpractice payments made on behalf of physicians, and adverse actions relating to physicians and dentists such as licensure, clinical privilege, professional society membership actions and exclusions from Medicare and Medicaid. This information was available to hospitals and health care entities with formal peer review procedures. Adverse licensing information on health care providers, practitioners and entities was added to NPDB when Social Security Act section 1921 was implemented. The section 1921 information essentially duplicated the adverse licensure information in HIPDB and was the impetus for combining the two databanks.

Information currently collected and disclosed as permitted by the NPDB includes information on medical malpractice payments, state licensure and certification actions against health care practitioners, entities, providers and suppliers; negative actions or findings by peer review organizations and private accreditation organizations; as well as

certain final adverse actions taken by state law enforcement agencies, State Medicaid Fraud Control Units, and state agencies administering or supervising the administration of state health care programs. These final adverse actions include exclusions from a state health care program, health care-related criminal convictions and civil judgments in state court, and other adjudicated actions or decisions specified in regulations. Access to information did not change with the consolidation. Basically, queriers have access to whatever information they had access to prior to the consolidation.

Though the NPDB does not have the ability to refer potential subjects to OIG for exclusion consideration, it does provide information that could be helpful in the furtherance of exclusion investigations gained through other sources. To assist with our exclusion program, OIG would find it helpful in addition to our current access level, to gain access to all information available under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended., Additionally, the OIG would seek a waiving of the per query fee for search in the NPDB.

Access to Enhanced Data

The NPDB was originally established by Title IV of the Health Care Quality Improvement Act of 1986, Public Law 99-660. The intent of Title IV was to improve the quality of health care by encouraging State Licensing Boards, professional societies, hospitals, and other health care entities to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history. These adverse actions against physicians and dentists include medical malpractice payments, certain licensure actions (to which OIG had access via HIPDB and continues to have access in the consolidated NPDB), clinical privileges, and professional society membership actions, as well as Drug Enforcement Agency controlled substance registration actions and exclusions from participation in Medicare, Medicaid, and other Federal health care programs (OIG had access to exclusions information via HIPDB and continues to have access to this information in the consolidated NPDB). Historically, OIG has been barred from the NPDB information that was not duplicated in HIPDB because the statutory and regulatory wording limits access to the original NPDB information to hospitals, professional societies with formal peer review, state licensing boards and the subject(s) of the adverse reports. Gaining information related to adverse actions would assist the OIG in identifying potential factors in support of an exclusion investigation.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

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July 18, 2014

Ms. Kathleen M. King
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Ms. King:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, June 25, 2014, to testify at the hearing entitled "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, August 1, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

August 1, 2014

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

Response to Questions for the Record from June 25, 2014 hearing "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"

Dear Mr. Chairman:

Enclosed please find our response to the questions you asked us regarding your June 25, 2014 hearing, "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse." If you or your staff have any questions about this response, please contact me at (202) 512-7114 or kingk@gao.gov.

Sincerely yours,

Kathleen M. King

Kathleen M. King
Director, Health Care

Enclosure - I

cc: The Honorable Diana DeGette
Ranking Member

Enclosure I

The Honorable Tim Murphy

1. Are Medicare contractors able to share such information with each other? For instance, if a patient or provider is suspected of fraud and they change plans during open enrollment would the plan a beneficiary is leaving be able to communicate with a plan they are joining about the suspected fraud?

In prior GAO work examining instances of questionable access to prescription drugs in the Medicare program,[1] CMS officials indicated that Medicare Part D plan sponsors are not allowed to share beneficiary information with other plans. GAO is unaware whether CMS applies this policy to Part C health plans.

CMS officials have reported that health plans receive fraud alerts from the agency describing information about reported fraud schemes, and representatives from the health plans are able to meet with CMS, NBI MEDIC, and law enforcement officials in quarterly Medicare Parts C and D Fraud Work Group meetings to share information about specific fraud schemes.

2. Medicare Administrative Contractors, known as "MACs" were created about a decade ago. Today they serve as the primary bill-payers for Medicare claims. Given that the bulk of Medicare reimbursements are processed by MACs, the bulk of improper payments are made by MACs. I know GAO is currently wrapping up work examining the work of the MACs. Do you have any early observations on your work that you can share with the Committee?

We have three research objectives for our current work on MACs: (1) How have the MAC contract costs and scope of responsibilities changed since the implementation of contractor reform?; (2) What alternative or additional contract incentives, if any, could CMS use to improve the operational efficiency and effectiveness of the MACs?; (3) What lessons learned, if any, since CMS implemented contractor reform could be used to increase MAC effectiveness and efficiency or to inform CMS's management of the MACs? We do not have early observations at this point, but expect to issue a report covering these objectives later this year.

3. GAO has conducted work looking at CMS's management of all program integrity contractors. GAO made several interesting findings, including the fact that CMS did not standardize its requirements for all contractors. One of the consistent findings from GAO's work over the years is that CMS will often sign a contract for a program integrity function, but either fail to measure the right functionality and activities from the contractor, or fail to assess progress as the contractor conducts the work. In what ways do you think the current contracting mechanism that CMS uses (which is subject to Federal Acquisition Rules), might hinder CMS's flexibility to manage the program well?

As noted in our work, CMS's requirements for certain contractors and its oversight activities could be improved, providing opportunities for CMS within its current contracting mechanism to improve its management of these contractors. As we reported in July 2013,[2] the differences in

[1]GAO, *Medicare Part D: Instances of Questionable Access to Prescription Drugs,* GAO-11-699 (Washington, D.C.: Sept. 6, 2011).

[2]GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency,* GAO-13-522 (Washington, D.C.: July 23, 2013).

CMS's postpayment claims review requirements for four types of contractors may reduce the efficiency and effectiveness of claims reviews by complicating providers' compliance with the requirements. We recommended that CMS examine all postpayment review requirements for contractors to determine whether they could be made more consistent without negative effects on program integrity. We also recommended that CMS reduce differences in those requirements where it can be done without impeding the efficiency of its efforts to reduce improper payments. In our opinion, these recommendations can be implemented in a manner consistent with the Federal Acquisition Regulation, which provides agencies with the flexibility to develop contract requirements that best suit their needs. In commenting on that report, CMS agreed with our recommendations and stated that the agency was beginning to review its requirements for postpayment claims reviews. We are following up on this work with a study reviewing, among other things, whether CMS has strategies for coordinating postpayment review contractors' claims review activities. That report will be issued this summer.

Additionally, in October 2013,[3] GAO reported that CMS lacks information on the timeliness of Zone Program Integrity Contractors' (ZPIC) actions—such as the time it takes between identifying a suspect provider and taking actions to stop that provider from receiving potentially fraudulent Medicare payments—and would benefit from knowing if ZPICs could save more money by acting more quickly. Also, GAO found that CMS's evaluation of measures relating to the quality of ZPIC work, while a best practice, does not connect ZPIC work to agency performance measures. For example, CMS aims to increase the percentage of actions taken against certain high risk Medicare providers—work central to ZPICs—but does not explicitly link ZPICs' work to the agency's progress toward that goal, another best practice that would allow the agency to better assess the ZPICs' support of CMS's fraud prevention efforts. Consequently, GAO recommended that CMS collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions, and develop ZPIC performance measures that explicitly link ZPICs' work to Medicare program integrity performance measures and goals.

4. In other work conducted for Congress, GAO has found two models for managing some offices within HHS (not at CMS, but at FDA). In one approach, individual employees received a portion of their bonuses based on that employee's individual contribution toward stated agency goals. In the other approach, the office had a general commitment to achieving stated agency goals, but the individual employees' contribution toward those goals was not assessed. GAO also found that the latter office significantly failed to advance agency goals in a meaningful way.

In 2012, we issued a descriptive report that provided information on the standards that FDA considers when assessing the performance of its employees.[4] We found that timeliness goals for reviewing medical product applications—including applications to market a new drug or device in the United States—are one aspect that FDA may consider in assessing employee performance. We found that the extent to which these goals are reflected as explicit expectations in employee performance standards varies by an employee's duties, level of responsibility, and organizational component. However, we did not examine the relationship between bonus payments to employees and their contributions to agency goals. In addition, we did not compare different management approaches in determining employees' bonuses or

[3]GAO, *Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight*, GAO-14-111 (Washington, D.C.: Oct. 25, 2013).

[4]GAO, *Food and Drug Administration: Employee Performance Standards for the Timely Review of Medical Product Applications*, GAO-12-650R (Washington, D.C.: Apr 18, 2012).

assessing employee performance. Accordingly, we did not report on the success or failure of such approaches.

a. Do you think there are any lessons in this management model for CMS's program integrity staff?

We have not conducted relevant work to answer this question.

b. Should the individuals who write or manage the contracts for program integrity contractors at CMS have some portion of their bonus held in reserve to be paid out based on the successfulness of the contractor actually reducing waste, fraud, and abuse?

Members of the CMS acquisition workforce who develop, award, and manage contracts – including program integrity contracts – seek to ensure that the agency obtains the goods and services it needs in a timely manner and at a fair price. They use a number of approaches to achieve that outcome, such as drafting clear requirements, seeking competition, and selecting reliable contractors. Through the use of these approaches, combined with informed contract monitoring, the agency expects that the selected contractor will perform as promised in the contract. For a contract to be successful, both the contractor and the agency do their part. Therefore, because success of a contract depends at least in part on factors outside the control of the agency, we believe it would not be appropriate to assess a monetary penalty against agency personnel merely because a contract within their purview is less than fully successful.

5. The CMS has agreed to postpone awarding the new round of Recovery Audit Contractor contracts until at least Aug. 15 because of pending litigation. This delay comes after numerous administrative changes and delays to the statutorily mandated program. Given the RACs record of recovering hundreds of millions, even billions, of dollars for the Medicare Trust Fund, does GAO have any concerns regarding the impact further administrative or legal delays may have on the effectiveness of the recoveries for the Medicare Trust Fund from the statutorily mandated program?

CMS has instituted a hiatus of the Medicare Fee-For-Service (FFS) Recovery Audit program for the current recovery audit contractors (RAC) as of June 1, 2014. The effect of the hiatus on the Medicare Trust Fund is unknown at this point. CMS has not made an announcement about new contractors. Under the current contractors, the RACs could review claims paid within the prior 3 years. Assuming CMS institutes the same look-back period under the new contracts, the new RACs will be able to review claims during the hiatus period.

6. What do you believe are the top 5 vulnerabilities with regard to the integrity of Medicaid payments?

While not exhaustive, GAO's work on Medicaid program integrity suggests several areas where additional actions could improve oversight of Medicaid payments. These areas include

- holding states accountable for, and providing updated guidance on, effective program integrity practices in Medicaid managed care;[5]

[5]GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014).

- ensuring that states correctly report overpayments identified by federal audits;[6]
- making use of knowledge gained from CMS reviews of states program integrity efforts to better target CMS audit resources towards states that have structural or data-analysis vulnerabilities;[7] and
- taking steps to integrate claims information and improve CMS's ability to detect fraud, waste, and abuse.[8]

The Honorable Tim Murphy

1. What is the likelihood of someone charged with Medicare fraud serving time in prison? What is the likelihood of someone charged with Medicare fraud paying a fine?

2. What is the success rate of Medicare fraud investigations?

We can't answer these questions specifically with respect to Medicare, but a recent GAO report provided some relevant information regarding fraud in Medicare, Medicaid and the Children's Health Insurance Program.[9]

- For criminal health fraud cases, we found that about 85 percent of subjects whose investigations were closed in 2010 were not referred for prosecution. Among those who were pursued by the Department of Justice, over 85 percent were convicted, pled guilty or pled no contest to some or all of the criminal charges against them. Among those found guilty, or who pled guilty or no contest, 60 percent were sentenced to incarceration and 48 percent were required to pay a fine.
- For civil fraud cases, we found that 47 percent of subjects whose investigations were closed in 2010 were pursued by the Department of Justice. The government obtained a favorable judgment or settlement against 55 percent of the subjects who were pursued. Finally, for those subjects with a judgment or settlement, 15 percent were required to pay a fine.

3. What additional data would be valuable to help you prescreen for Medicare fraud?

We think this question was intended for CMS, not GAO, since CMS is responsible for screening through enrollment for Medicare fraud.

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[6]GAO, *Medicaid: CMS Should Ensure That States Clearly Report Overpayments*, GAO-14-25 (Washington, D.C.: Dec. 6, 2013).

[7]GAO, *Medicaid Program Integrity: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, GAO-13-50 (Washington, D.C.: Nov. 13, 2012).

[8]GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

[9]GAO, *Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases*, GAO-12-820 (Washington, D.C.: Sept. 7, 2012).

The Honorable Bill Johnson

1. Are Medicare contractors able to share information with each other? For instance, if a patient or provider is suspected of fraud and they change plans during open enrollment would the plan a beneficiary is leaving be able to communicate with a plan they are joining about the suspected fraud?

In prior GAO work examining instances of questionable access to prescription drugs in the Medicare program,[10] CMS officials indicated that Medicare Part D plan sponsors are not allowed to share beneficiary information with other plans. GAO is unaware whether CMS applies this policy to Part C health plans.
CMS officials have reported that health plans receive fraud alerts from the agency describing information about reported fraud schemes, and representatives from the health plans are able to meet with CMS, NBI MEDIC, and law enforcement officials in quarterly Medicare Parts C and D Fraud Work Group meetings to share information about specific fraud schemes.

The Honorable Billy Long

1. What percentage of the 350,000 cases that will be adjudicated were initially correct and holding the money?

Until those appeals are adjudicated, information will not be available to determine whether the underlying determinations were upheld or overturned.

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[10]GAO, *Medicare Part D: Instances of Questionable Access to Prescription Drugs*, GAO-11-699 (Washington, D.C.: Sept. 6, 2011).